

Managed competition for the poor or poorly managed competition? Lessons from the Colombian health reform experience

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Background: In 1993, Colombia enacted and subsequently implemented a radical reform in its system of providing health care for the poor, moving in a short time from a traditional model of providing health services in public hospitals to a managed competition model in which the government buys health insurance for the poor. This study examines and attempts to draw lessons from the early experience with this reform.

Methods: Information was gathered from document reviews and interviews with key actors at both the national and local levels. Other quantitative data, such as data from existing national surveys and financial operating data, were also used as available.

Results: The new system made important achievements in its first few years, including the enrolment of 7 million Colombians (about half of the targeted population) in health insurance plans and improving access to care. Nevertheless, there were substantial problems with the lack of managerial infrastructure and flow of information needed for the new system to function properly. Because of these difficulties, substantial resources were wasted, and insurance coverage did not always result in true access to health care.

Conclusions: Other countries contemplating similar reforms should educate health administrators and the public, and establish solid administrative capacity in advance of implementation. In Colombia, many initial problems still need to be overcome while maintaining and extending the programme's important accomplishments.

Introduction

Many developed countries have incorporated a managed competition model into various aspects of their health care systems.^{1–7} Research from these countries indicates that the managed competition model has the potential for lowering costs and reducing unnecessary services and for providing more comprehensive services for the poor than traditional 'charity care'.⁸

On the other hand, experience elsewhere has indicated that managed competition can be successful only if it leads to more efficient resource use, while maintaining a large degree of equity in the system.⁵ Consumers' and providers' reception of managed competition has also been mixed.⁹ Managed competition has been widely applied in the private sector and also as a mechanism for the government to purchase health insurance for the poor.

Experience with managed competition in the developing world is much more limited and has mainly involved the private sector.^{6,10–12} One outstanding exception to this has been the experience in Colombia. In 1993, Colombia enacted 'Law 100' which radically transformed its system for providing health care for the poor from a traditional supply-based model to a new model in which the government purchases

managed care insurance for the poor from competing insurers. Through enabling legislation, Colombia implemented managed competition broadly throughout the whole country before first testing its feasibility. The Colombian experience thus can be considered the first large-scale experiment with managed competition so far conducted in the developing world.¹¹

This article does not focus on the rather surprising and complicated political background to these reforms, which has been discussed elsewhere.^{13,14} In brief, a new constitution enacted in 1991 declared that health services should be available to everyone. Subsequent attempts to reach consensus on how to implement this were unsuccessful. This was followed by the rapid elaboration and enactment of a plan favoured by key actors in the executive branch that took place in a context of general political upheaval.

This article examines and analyzes the process of implementation of the new Colombian subsidized insurance system and documents its achievements and difficulties. We attempt to identify important lessons by drawing on the evidence from both the national level and local case studies that we conducted. Our goal was to examine the initial experience in Colombia to seek lessons that might guide the future evolution of the system in Colombia and be helpful to other

countries, especially those in the developing world, contemplating similar reforms. We also address the question of whether insurance coverage has resulted in improved access to health care.

Background

Prior to Law 100, the Colombian health system was composed of the private social security system and a public system based on a supply model, in which public hospitals received resources directly from the government and were responsible for providing health care, particularly for the low-income population. Although the poor were supposed to have access to free or low cost health care through this system, their access was often, in fact, quite limited, mostly due to inability to pay. This situation encouraged a reform that introduced a demand-based model, in which ‘resources follow the patient’, as a mechanism designed to increase access (see Figure 1). It established social insurance to provide universal coverage in the form of a standard benefit package, administered by competing health insurers. Risk adjusted premiums are fixed by the state, so that competition is based on quality rather than price.

The law specifies two systems: the contributory and the subsidized. The former covers the population with the ability

to pay and is financed through employer and employee contributions for those with formal jobs through a tax of 12% of income. One twelfth of the resources collected from this system as well as additional resources from the Ministry of Health go to a subsidized system. The subsidized system covers the poor population, who are identified through the ‘proxy means test’, a door-to-door survey carried out by the municipalities. The whole health system is administered in a decentralized process, which implies the transfer of political, financial and administrative resources as well as decision-making powers to local governments. Therefore the local governments are largely responsible for executing the reform. As shown in the figure (the arrows represent the flow of resources), institutions at the national level allocate resources directly to the local governments, which are responsible for identifying and purchasing health insurance for the poor. Once the potential beneficiaries have been chosen and the availability of resources determined, the number of enrollees is established. The eligible population is allowed to choose from new competing private and public insurance companies (ARS). The ARSs receive premiums from the local governments and pay for services from hospitals and other medical providers.

Benefits covered under the contributory plan include the full

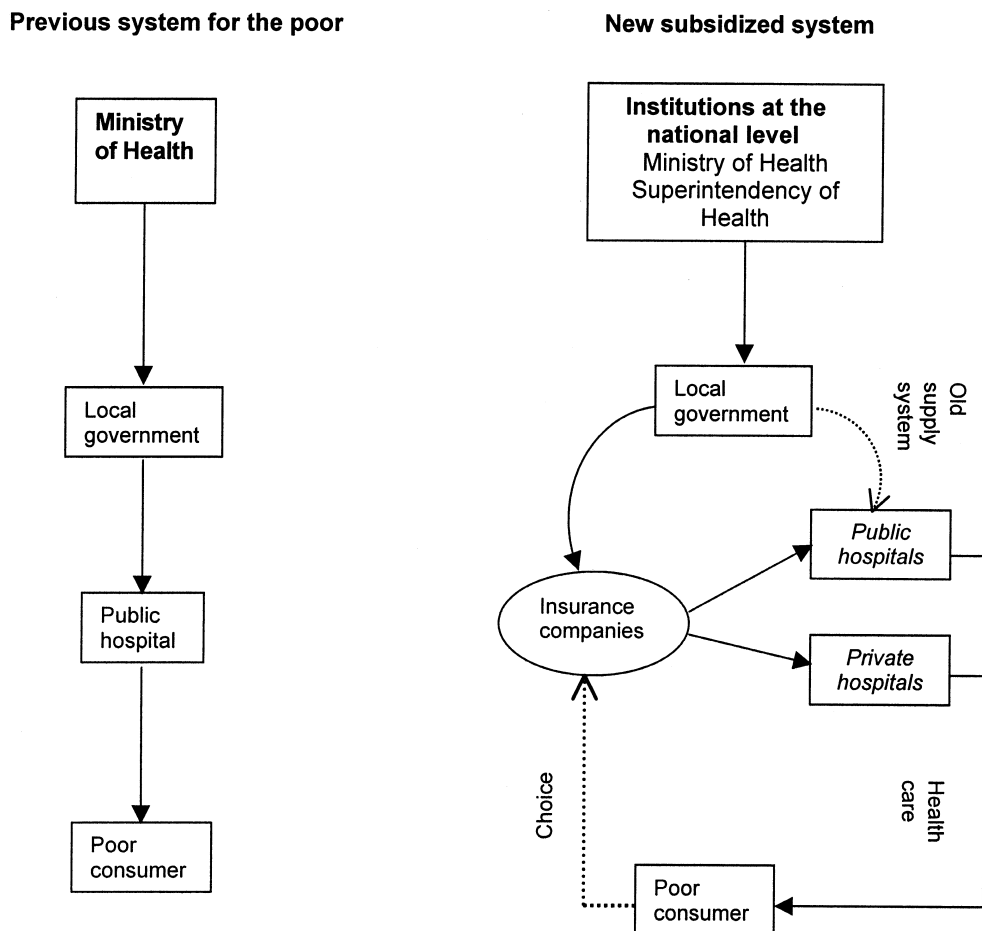


Figure 1. The previous and new public healthcare systems in Colombia

range of medical services available in the Colombian health care system. The subsidized system, on the other hand, covers a less comprehensive package of benefits that emphasizes prevention and primary care, including medications provided in the context of these services. Beyond this, only a specified list of more complicated conditions and procedures is covered. This was quite limited initially but has been gradually expanded with the goal of eventually matching the contributory system. For example, coverage for catastrophic illness, including cancer, AIDS, cardiovascular disease, and major trauma, was added to the subsidized system in 1996.¹³

Methods

Given that this study analyzes the implementation of a new policy, both qualitative and quantitative methods were used. The analysis of the process of implementation of the subsidized system was based on qualitative data, gathered through interviews and document review at both the national and local levels and describing how the new system was put into practice. National and local data were both analyzed to understand the institutional framework and the operational structure. Quantitative data about coverage, utilization and socioeconomic characteristics of enrollees were also collected.

At the national level, we administered semi-structured interviews to policymakers and other key actors in the reform process, including politicians and representatives of government, the Hospital Association, the Ministry of Health, the Medical Trade Union, and the insurance companies. The objective of these interviews was to learn their perception of the structure of the reform and the mechanisms it established to achieve its objectives, as well as the evolution of the implementation process. The sample was selected to reflect the participants' various positions and interests in the reform process. Of 22 individuals invited to participate, 14 agreed to be interviewed. Most of those who did not agree to participate belonged to sectors opposed to the reform. Although refusers did not give reasons, they may have believed that participating in the project could either support the reform process or expose their lack of cooperation with it.

At the local level, case studies were carried out to examine the local process of implementation. We chose a purposive sample of 16 municipalities for detailed case studies that covered the four major cities in Colombia and three municipalities in areas surrounding each of these cities. This selection was based on a variety of factors including the percentage of the population covered, demographic characteristics, and population size, among others. The goal was to include a broad range of communities rather than a representative sample, basically for two reasons: (1) to include in our sample the deep socioeconomic differences present in Colombia, and (2) to analyze to what extent these differences could influence the local evolution of the system and to thereby gain a full overview of the implementation process at the local level. As such, the approach was mainly synthetic rather than comparative.

In each of these municipalities, the main actors involved in the local implementation process (6 to 7 key individuals) were

interviewed, including the municipal health administrator, two to three insurance company officers, the mayor, the director of the local hospital, and representatives of consumer associations. One to two-hour open-ended interviews were performed. All the questionnaires followed the same basic structure but had additional specific sections pertaining to the roles of each of these actors/institutions. The purpose of these interviews was to identify the extent of knowledge regarding the individuals' specific responsibilities, their role in the implementation process, and their perceptions regarding how the system was working. The questionnaires were structured to allow cross checking of interviewee's perception of each other's roles and performance. Further details concerning the methodology of these case studies and interviews are available upon request. Documents produced by the aforementioned local institutions and local NGOs were also reviewed as part of the local case studies.

Quantitative data about utilization of health care and insurance coverage were collected from the 1992 National Household Survey and the 1997 National Quality of Life Survey. Since the former survey provides data prior to the enactment of Law 100, and the latter was conducted while the reform was being applied, they provide information about the trend in self-reported insurance coverage and access to care. Data about coverage and percentage of poor in the population come from Ministry of Health documents. Documents and reports about the political process, conception of the reform, and the evolution of the system were reviewed. The sources were mainly the Ministry of Health, the Fiscal Control Department of this ministry (Superintendencia de Salud)ⁱ and the National Planning Department, but a few relevant independent research studies were also considered.¹⁵⁻¹⁷ Data presented in this report cover the first few years of the new system, from its inception until about 1998.

Results

Achievements

The most important achievement of the subsidized system has been the enrolment of a large number of poor people into the new system. According to the Ministry of Health, nationally, approximately 50% of the eligible population has been identified and enrolled in the subsidized insurance plan. This represents more than 7 million Colombians who now have health insurance through the subsidized system. Figure 2 shows the percentage of Colombians covered by both the subsidized and the contributory system in 1993 and 1997.¹⁴ This demonstrates that the creation of the subsidized system has increased the percentage of people with insurance, not simply shifted people from one system to another. In fact, coverage under the contributory system has increased, even while the new subsidized system has been added. This increase was largely due to new rules that include more family members.

The large increase in Colombians with health insurance is confirmed by independent survey data. According to the National Household Survey, 28% had any type of health insurance in 1992. By 1997, four years after the enactment of

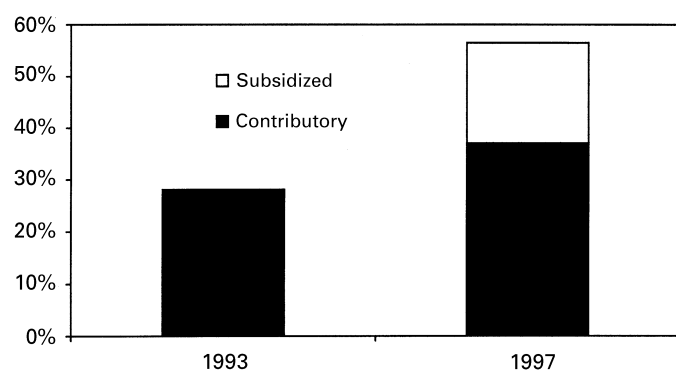


Figure 2. Percentage of Colombian population with health insurance. *Source:* National Household Survey 1992 (Harvard Report, 1996) and Quality of Life Survey 1997

Law 100, this had risen to 57% according to the National Quality of Life Survey. While a small proportion of people covered under the new subsidized system may have had insurance previously (e.g. some dependents of individuals included in the contributory system or with private insurance), these data clearly show that the great majority were people who had not had health insurance previously.

Data on access are much more difficult to obtain, but can be approximated by similar questions asked in the national surveys in 1992 and 1997. In the 1992 survey, 51% of those who reported not seeing a doctor when they were sick said that this was because it was too expensive.¹⁵ Results from the 1997 survey show that the percentage had decreased to 41%. This indicates that since the enactment of Law 100, the proportion of individuals who do not receive services because they are too expensive has fallen.

As shown in Table 1, the percentage of eligible people enrolled in the system as of 1997 varied widely in the 16 communities we studied. The main determinant of coverage seemed to be the availability of resources, with rich districts, such as Bogotá, or districts where a better job was done of getting resources for the program from the national level, such as La Mesa, having higher coverage. Levels of coverage of near 100%, as reported by a few districts, represent enrolment of some families above the official poverty line, even though they were not supposed to be eligible. Nevertheless, we found in the case studies that factors other than money also influence the level of enrolment. As will be discussed in the following section, these include the way in which the implementation process was conducted and the speed at which management capacity was developed. While these levels of enrolment do not necessarily represent true access, they are the best indicator currently available.

The enactment and survival of Law 100 has itself been a major achievement. It radically transformed the Colombian health care system in a short period of time. It took only approximately 2 years from when the law was initially proposed to when it was enacted (1993). Implementation began the following year (1994). This rapid 'big bang' implementation of a radical new reform is unique among recent health sector reforms in Latin America and in the history of political reform in Colombia in general.¹⁷ During its first 5 years, it survived three governments and five ministers of health with different opinions and views, thus demonstrating public support. When we asked key national actors 'If you had the opportunity to reform the subsidized system, what would you do?', not one of the respondents said they would eliminate the system; rather, they said they would adjust it to correct implementation problems.

Finally, the law has transformed the relationship between the

Table 1. Case studies: population numbers, rural population, poor population and the poor's enrollment in subsidized insurance in Colombian municipalities

Municipality	Population (in 1000s)	Rural population (%)	% of population classified as poor ^a	% of poor population enrolled
Bogotá	6 316	1	16	94
Cali	1 986	2	11	87
Medellín	1 971	5	17	68
Barranquilla	1 158	1	37	24
Buenaventura	282	17	63	18
Puerto Tejada	40	14	45	38
Silvia	29	80	66	63
La Mesa	19	57	77	51
Zipaquirá	69	13	14	79
Ventaquemada	11	89	38	63
El Peñol	15	58	83	68
Santa Rosa Osos	23	62	95	46
Rionegro	70	36	50	32
Tubará	11	36	76	22
Puerto Colombia	25	42	44	37
Soledad	238	1	41	17

Source: Plaza and Barona, 1999.¹³

^a Based on the door-to-door survey carried out by each municipality. Income levels I and II were included.

poor who are covered by the system and health care providers. Whereas before, the poor could only receive 'charity care' from the public sector, they are now entitled to receive health services by the public or private system through their insurance. As stated by the Secretary of Health in Cali, "Yes it (access) has improved. People now have an insurance card, they feel as though they have an entitlement."

Difficulties

Despite the important achievements mentioned, there have also been substantial operational difficulties in the subsidized system that have affected the adequate development of the system as a whole. We grouped our main findings into three trouble areas/types of difficulties: (1) lack of institutional capacity, (2) information stumbling blocks, and (3) delays in the flow of resources.

Differences within the municipalities are reflected both in the different levels of coverage among the poor and in the variations of true access to care among those who are covered. As mentioned above, the coverage level in the municipalities depends very much on the resources available and, as can be seen in Table 1, there are significant differences among them. The extent to which local governments and hospitals have been able to adjust their structures to the new system and the performance of the competitive insurance market also help determine the how far the system is institutionalized and its impact on health care for the poor.

Deficient institutional capacity at various levels

The enactment of the new law required existing institutions, such as the Ministry of Health, local government authorities and the public hospitals, to assume substantially new responsibilities for which they were often unprepared. Also, the entrance of new institutions, such as insurance companies, required them to adapt to the system and readjust their functions within it. At the national level, co-ordination and organization of the system was difficult, while at the local level, institutions seem to have had limited understanding of the overall scope of the reform and how crucial their role was in the process.

The Ministry of Health, in charge of the system, had the task of co-ordinating the reform process. Through consistent instructions and close guidance, local authorities were to properly implement the new subsidized system. Unfortunately, direction from the Ministry was not always timely or consistent. Local authorities and other actors complained about an endless stream of regulations that created more confusion than guidance. Complaints about this were common in the interviews at all levels. Also, the perception of lack of leadership of the Ministry and the limited integration within the system were recurrent themes.

In 1995, when the subsidized system began, there did not seem to be clarity about the implementation process at the local level. Provisional methods to identify and enrol the majority of potential users were applied. Initially, instead of carrying out the proposed door-to-door survey, a strata

characterization based on household public service payments was applied. (In Colombia, households pay for electricity, water and telephone services according to the socioeconomic characteristics of the neighbourhood. The rich pay more, thus subsidizing the poor.) Prior to the creation of the insurance companies, the poor were directly but temporarily insured by the local health secretariat. This led to much confusion, both for local governments and consumers, who in one year were subjected to multiple identification, enrolment and delivery processes.

Another new responsibility of the Ministry of Health was to regulate and supervise a large new market of managed care programmes for the poor. At the beginning of the process, there were considerable gaps, which resulted in frequent abuse by the insurance companies. For example, some companies 'enrolled' people without issuing identification cards, thereby receiving premiums without providing services. The different insurance providers who were supposed to compete for customers sometimes made 'non-aggression agreements' during open enrolment to avoid competition. Some insurers intentionally avoided segments of the poor population, limiting the free choice that consumers were supposed to enjoy. Other insurers provided kickbacks or spread false information about competitors to gain customers. Recently, the Ministry of Health appears to be doing a better job with its regulatory functions, and some of these abuses have become less frequent.

At the local level, governments were given the responsibility to individually identify the poor for the purposes of enrolment in health insurance. A system for doing this, called SISBEN, was adopted, in which local health authorities were to visit households in their areas and administer a standardized questionnaire. This all occurred simultaneously with a general decentralization process, in which numerous other tasks, both in health and other areas of government, were delegated to the local level. In our case studies, we found that identification of eligible households was sometimes limited only to central urban areas, while rural areas and urban squatter communities were often ignored. Among the most common complaints mentioned in interviews about the targeting process were the technical mechanisms used in the SISBEN and the preferential application of the instrument in favoured communities for political purposes. Neither migratory populations nor the special needs of other groups of poor were taken into consideration. Many believed that a standardized questionnaire is not appropriate in a country with deep regional differences.

Finally, the public hospitals were pressed into a new competitive system to sell their services and compete with the private sector in the delivery of health care. They had to transform their administrative structures into completely new ones, where the areas of accounting, marketing and billing had to be created from scratch. Public hospitals were not prepared to take on this task of transformation, as has become evident from the weakness of capacity in these new areas along with the resistance of public hospital employees. As one respondent said, "First of all, there is great disagreement about how they (hospitals) should adjust to the new system.

Health care supply in Colombia was not ready for the enactment of Law 100: most hospitals do not have accounting systems; information systems are not unified and therefore are unable to exchange information; many hospitals have not been modernized in order to be able to carry out the terms of the new law; the insurance companies are not yet prepared to negotiate with the health care providers.”

Hospitals also faced conflicting messages: on the one hand, they were meant to be autonomous and self-sustaining, while on the other hand, centralized decisions continued to be imposed on them, thus affecting their way of functioning. Such was the case in wage negotiations between the Ministry of Health and the health trade unions, where public hospital directors were excluded.

Deficient information channels

Another major problem in the subsidized system has been with flow of information. At the central level, all of the actors involved, including the Ministry of Health, the social security system and the insurers, attempted to collect various types of data for administrative and financial reasons. These efforts were not co-ordinated, so that while, on the one hand, there has been a proliferation of unneeded and duplicated information, on the other hand, those who need information to make decisions often do not have access to it. Administrators of public hospitals, in particular, feel that they do not have the information they need for delivering services and contracting with health insurance companies.

But the group suffering most from lack of information has often been those that the system was designed to benefit. Many of the poor know neither how the system is supposed to work nor their rights under the system. This has contributed to incomplete enrolment among the eligible poor. Informants frequently described situations where people who had been issued insurance cards had no idea how to use them. They would often continue to pay out of pocket for health services or not receive needed services at all. As stated by a social worker in Buenaventura,

“People feel happy, they speak beautifully about the opportunity they have been given. But the people weren’t well orientated about their rights, they don’t know what to demand nor where to demand; the ARSs have not done this adequately”.

“Another problem is that there are many people who have not even received an insurance card, and the hospitals do not have databases of the people affiliated to each ARS.”

Other enrolees would try to obtain multiple insurance cards from different companies, thinking that if one is good, two must be better, even though all the plans offer identical benefits. Often, these misconceptions work to the benefit of the insurers since they result in lower costs per enrolee. Thus, it is clearly necessary for the government to educate users on how the system works, rather than relying on the insurance companies to do so.

Inadequate flow of resources

This difficulty is closely related to the problem of institutional capacity. The lack of clarity in the way resources should flow within the system has not allowed it to meet the needs of the population in the subsidized system. The backup begins with the Social Insurance Fund, which is responsible for sending resources to the local government, who then should send the risk-adjusted premiums to the health insurers according to the number of enrolees they have, who then should pay the hospitals for the services rendered. Each step in this process has been subject to extended delays. The hardest hit in this vicious circle are the public hospitals. If they do not receive the resources for the population they serve then they are forced to continue financing services themselves through supply side funds rather than selling their services, thus not allowing for complete transformation from a supply side model to a demand model. In fact, the traditional supply side model has continued to co-exist in the public hospitals alongside the new demand model so that, in many cases, the government is paying double to care for the poor.

Discussion

This study, which demonstrates important accomplishments and difficulties of the new Colombian system of managed competition for the poor, has several potential weaknesses. As noted above, participation in interviews by key national figures in the reform process was greater among proponents than among opponents of the new system. This may have biased the results towards a more positive interpretation of the goals and accomplishments of the new system. However, participation at the level of the local case studies was nearly universal, and there was no reluctance among interviewees to point out the problems of the system. Another potential weakness is that the Ministry of Health provided most of the quantitative data presented on enrolment, and it might be in their interest to overstate the extent of enrolment of the poor in the subsidized system. However, the data they provided were consistent with the data from independent national surveys and our impressions from the local case studies.

Our case studies were carried out in Colombia’s four major cities and their surrounding areas. The findings therefore do not necessarily generalize to more remote areas of the country and certainly not to areas outside government control in the current civil war. The same limitation applies to several of the secondary data sources we used. Also, reliable data on the quality and utilization of services provided under both the old and new systems are practically non-existent. Perhaps the greatest weakness of this study is that the managed competition system is still new, and its ultimate impact is as yet unknown. Nevertheless, we believe there are important lessons to be drawn from the early experience of its implementation that may be useful in Colombia and elsewhere.

The main achievement of the Colombian subsidized health system is that it managed to provide insurance coverage to approximately half of the poor population in a short period of time. However, as described, several difficulties emerged in

the process of transforming the reform into practice. Weak institutional capacity may have been the most important hindrance. Additionally, the lack of integration within the system and the deficiency of knowledge concerning the responsibilities and roles of each institution have led to problems in both flow of resources and information channels.

We believe that, in general, the subsidized system established an appropriate institutional framework and mechanisms to improve health care for the poor through insurance coverage. However, based on the case studies and interviews conducted, we can conclude that the optimum conditions for service utilization have not been realised, mostly due to having a system that is poorly managed. Therefore, not all the poor are covered and coverage has not always translated into real access. Given that the operation of the system has not yet stabilized, it is still not fully oriented towards the beneficiaries and thus only partially provides them with the tools they need to access the system. This is manifested by various stumbling blocks, such as a limited knowledge of users' entitlements, resulting in users making out-of-pocket payments, the government paying double, problems in identifying the target populations, and other problems already mentioned. Indeed, it might be argued that, were such a thing possible, similar or even greater gains in access to care might have been achieved by simply applying the increased resources that went into the new system without any of the structural reforms.

An ideal health insurance system can take time to design, as can educating key actors and the public about how it is supposed to work. This is part of a social development process. The risks of going too fast in an implementation process can lead to constant adjustments and, even worse, promises that cannot be kept and loss of confidence in the scheme and its managers. These problems were seen in the cases of Guatemala and the Philippines,¹² where the former had difficulty in establishing a health insurance scheme for the poor while the latter was more successful. Part of the difficulty or success was the existing management capacity and the need for continuous improvement of managerial capacity. It is also worth pointing out that a uniform blueprint for implementation is probably unachievable, given the different stages of socioeconomic development and management capacity of each country. However, as Ron¹² points out, it is not impossible if proper national guidelines, a formal accreditation process, and an umbrella organization to provide assistance are in place to accompany the process of implementation.

The radical Colombian reform was only possible at a certain brief political moment in time. Delaying its implementation until all the necessary tools were ready would probably have destroyed the whole project. The choice was not between doing it correctly or doing it wrongly; it was between doing it hastily or not doing it at all. However, this precipitous enactment has had a cost in terms of the many problems that have been encountered.

Lessons learned

The Colombian experience demonstrates the importance of establishing a solid institutional capacity to effectively run a

reform of such magnitude. Administrators of the new system and public hospitals in particular need the proper management instruments to function within a competitive market. We would recommend that countries contemplating similar reforms pay particular attention to helping actors at all levels develop the institutional capacity to successfully carry out their intended functions. This should, especially, include training in the financial and accounting skills necessary for providers to move from a supply to a demand model. Clear and complete regulations and instructions need to be disseminated and fully explained to all levels in advance. Clearly articulated rules at all institutional levels must be readily available to convert theory into practice.

Information about how the system functions, and particularly the users' rights, must be widely disseminated. The manner in which information is conveyed must be accessible for the users of the system to improve their demand capacity, which in turn will allow competitive forces to work. Identifying the poor and enrolling them is not sufficient; they must also know their rights within the system.

Colombia continues to face challenges in accomplishing its reform goals. It can only be hoped that, in the future, the initial difficulties of the managed competition system will be looked back upon as an unfortunate but necessary stage in developing a new system that has produced genuine benefits for the poor.

Endnotes

¹ The Superintendencia de Salud is responsible for supervising and controlling public and private health administrators.

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