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ENHANCING THE POLITICAL
FEASIBILITY OF HEALTH
REFORM:
THE COLOMBIA CASE

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ACRONYMS AND GLOSSARY

	SPANISH	ENGLISH
ACEMI	Asociación Colombiana de Medicina Prepagada	Association of Pre-paid Medicine Organizations
Independents	Trabajadores independientes	Self-employed: i.e. peddlers, taxi drivers
AD-M19	Alianza Democrática M-19	Democratic Alliance M-19
Affiliate	La persona que se afilia a la entidad promotora de salud	A person who pays a premium to enroll in an EPS
ANC	Asamblea Nacional Constituyente	National Constituent Assembly
ANDI	Asociación Nacional de Industriales	National Industry Association
ANIF	Asociación Nacional de Instituciones Financieras	National Association of Financial Institutions
ARS	Administradora Régimen Subsidiado	Subsidized Regime Administrators Agencies
ASCOFAME	Asociación Colombiana de Facultades de Medicina	Colombian Medical School Association
ASMEDAS	Asociación Médica Colombiana	Colombian Medical Association
ASOBANCARIA	Asociación Bancaria	Banks Association
AVISAs	Años de Vida Saludables Ajustados	Disability-Adjusted Life Years (DALYs)
CAJANAL	Caja Nacional de Previsión	National Prevision Institute
CCF	Cajas de Compensación Familiar	Cooperative Organization
CNSSS	Consejo Nacional de Seguridad Social en Salud	National Council for Social Security in Health
CONPES	Consejo Nacional de Política Económica y Social	National Council on Social and Economic Policy
CONSENSO	Consenso	Consensus (a think tank)
CUT	Central Unitaria de Trabajadores	Workers Unitary Union
DALYs	Años de Vida Saludable Ajustados	Disability-Adjusted Life Years
DAPRE	Departamento Administrativo de la Presidencia de la República	Administrative Department of the Presidency
DAS	Departamento Administrativo de Seguridad	Administrative Department of Security

DNP	Departamento Nacional de Planeación	National Planning Department
ECOPETROL	Empresa Colombiana de Petróleo	Colombian Oil Enterprise
ECV	Encuesta de Calidad de Vida	Quality of Life Survey
ELN	Ejército de Liberación Nacional	National Army for Liberation
Enrollee	Persona cubierta por una EPS: el afiliado o sus familiares	Person covered by an EPS: affiliate or his / her family members
EPS	Entidad Promotora de Salud	Organization to Promote Health Services
ESE	Empresas Sociales del Estado	A type of IPS
ESS	Empresas Solidarias de Salud	Health plans serving the subsidized population
FARC	Fuerzas Armadas Revolucionarias de Colombia	Colombian Revolutionary Armed Forces
FASECOLDA	Federación de Aseguradores Colombianos	Colombian Insurers Federation
FEDESARROLLO	Fundación para la Educación Superior y el Desarrollo	Foundation for Higher Education and Development
FENALCO	Federación Nacional de Comerciantes	National Federation of Merchants
FES	Fundación para la Educación Superior	Higher Education Foundation
FECODE	Federación Colombiana de Educadores	Colombian Teachers Federation
FESCOL	Fundación Friedrich Ebert de Colombia	Friedrich Ebert Foundation of Colombia
FNH	Fondo Nacional Hospitalario	National Hospitality Fund
FONSAT	Fondo Nacional de Seguros de Accidente de Tránsito	National Foundation of Traffic Accident Insurance
FOSYGA	Fondo de Solidaridad y Garantía	Solidarity Fund
FRB	Fundación Restrepo Barco	Restrepo Barco Foundation
ICBF	Instituto Colombiano de Bienestar Familiar	Colombian Institute of Family Welfare
IDB	Banco Interamericano de Desarrollo	Inter-American Development Bank
IPS	Instituciones Prestadoras de Servicios	Health Service Providers Institutions
ISS	Instituto de Seguros Sociales	Institute of Social Security
IVA	Impuesto de Valor Agregado	Value Added Tax (VAT)
M-19	Movimiento Revolucionario 19 de Abril	Revolutionary Movement 19 th of April
MOH	Ministerio de Salud	Ministry of Health
MP	Medicina Prepagada	Prepaid Medicine
MSN	Movimiento de Salvación Nacional	National Salvation Movement
NGO	Organización no Gubernamental	Non-Governmental Organization
PNR	Programa Nacional de Rehabilitación	National Program for Rehabilitation

PNUD	Programa de Naciones Unidas	United Nations Development Programme
POS	Plan Obligatorio de Salud	Mandatory Health Plan
POS-S	Plan Obligatorio de Salud Subsidiado	Mandatory Subsidized Health Plan
PRT	Partido Revolucionario de los Trabajadores	Workers Revolutionary Party
RAP	Prima con Ajuste de Riesgo	Risk Adjustment Premium
SAC	Sociedad de Agricultores de Colombia	Colombian Agriculture Society
SENA	Servicio Nacional de Aprendizaje	National Service of Education
SINTRA-ISS	Sindicato de Trabajadores del ISS	ISS Workers Union
SISBEN	Sistema de Identificación de Beneficiarios de los Subsidios del Estado	System for the Identification of Government Subsidies Recipients
SOAT	Tarifas para el Seguro de Accidentes de Tránsito	Tariff schedule of fee-for-service reimbursement for medical procedures
UP	Unión Patriótica	Patriotic Union (FARC political group)
UPC	Unidad de Pago por Capitación	Risk Adjusted per-capita Payment
USO	Unión Sindical Obrera	Workmen's Union
WB	Banco Mundial	World Bank

INTRODUCTION

The scope of the health reform envisioned in Colombia and the speed with which it was eventually implemented have captured the attention of the international public health community. Certain features of the reform; i.e., the fact that it was led by a team of economists from the more technocratic Planning Ministry, the emphasis on bringing about change through regulation, and a tendency to use market mechanisms to manage health funding and provision, led to obvious comparisons with the Chilean experience. While it can be argued that reformers in both countries resorted to similar strategies, the political economy in Colombia empowered other actors—notably legislators—who were able to promote radical change and then to influence its final form. The first stages of health reform in Colombia—incorporating the issue into the public agenda, passing legislation, and beginning implementation—happened more quickly in Colombia than in Chile. The authoritarian regime in Chile, contrary to many observer's expectations, was not able to act with greater dispatch than the more democratic regime in Colombia. On the other hand, Colombia's more democratic context left its imprint by making the reform's content more far-reaching, both in depth and scope. The Colombian effort was an attempt to change the totality of the system.

The Colombian health reform has prompted a significant transformation of the health sector and, in spite of many difficulties, has obtained significant achievements. The main gains have been the consolidation of new institutions within the contributory and the subsidized regimes that have contributed to the expansion of affiliation in social security coverage in health from 20% to 53%. Also, as a result of the reform efforts, significant new resources have been allocated to the health sector. Those achievements have been reflected in improvements in access to health care, greater equity, and efficiency gains within the contributory regime.

In spite of making significant progress in a short period of time, the reform has encountered serious difficulties in achieving its goals in full and its consolidation faces great difficulties. For example, while there has been an increase in affiliation, this has not always been reflected in better access to health services, particularly for the poor. Also, universal affiliation by the year 2001 with the same basic health care package (POS) for both the contributory and the subsidized regimes, will not be possible. Some of the difficulties the reform faces can be attributed to its complexity, which has not been matched by the level of human resources available, nor by the country's institutional capacity. This factor is particularly acute due to regional variations within the country. Furthermore, the political aspects of the policy change have played an important role in both promoting some elements of the reform, while impeding or halting others.

It can be said that the important achievements of the reform have been done primarily with new resources and through the new institutions, while those that existed before the reform have been very resistant to change. As a result, it is cause for concern that a process of segmentation is taking place. This is exacerbating the differences between the two regimes—contributory and subsidized—as well as between different income groups affiliated with the contributory regime. Marked differences between private and public health providers remain as well.

The reform's implementation has achieved many of its objectives in a short period of time. However, the second stage of the process in which the reform finds itself today is crucial not only in determining the overall affiliation level, but in consolidating it and making it sustainable. What lies ahead depends on the completion of the transition process that necessarily entails the transformation of the old providers and the reallocation of health resources along the lines envisioned in the reform.

POLITICAL ECONOMY CONTEXT

The political context in which the Colombian health reform of the early nineties was formulated, legislated, and began to be implemented, needs to be explored around a pivotal event—Colombia’s process of major State reform and the enactment of a new Constitution. This major institutional transformation was aimed at redefining the balance of power among the three branches of government, the relations between central and regional authorities, and the role of political parties. It was aimed at including those social groups that had previously been disenfranchised from the formal institutional political competition. The new strength acquired by Congress as a result of these reforms raised its negotiating power in policy making vis a vis the Executive. This new balance of power allowed the Congress to influence certain policy initiatives such as pension reform; and to impose others on the Executive, such as the health reform. Nevertheless, the Executive continued to be the center of policy decision-making and to hold enough power to impose its agenda on Congress.

Colombia is an electoral democracy—in fact, it is one of the oldest in the Region—and is characterized by party rotation. Policy decision making, however, remains exclusionary and elite-based. Political parties play an important role in elections and patronage, but not in policy making through a strong Congress. The Executive has significant policy-making powers. While formally all policy initiatives need to be sanctioned in Congress, a great deal of policy making remains exclusively in the domain of the Executive branch, which, for this purpose, resorts to Executive decrees. This situation, even when modified by the National Constituent Assembly (ANC), has been very important in the ability of the Executive to pursue policy change.

The Executive has furthered this ability with the creation, since the late eighties, of pockets of efficiency with various degrees of political support, particularly in economic agencies such as the Central Bank, the Ministry of Finance, and the National Planning Department. It is in these institutions that small groups of technocrats with the support of decision-makers, have played an important role in the formulation of reforms, particularly those related to economic issues. During the early nineteen-nineties as part of a major State reform agenda that included both the economic and social spheres, these teams were constituted and embedded in social sectors such as health and pensions, to develop proposals for social security reform.

However, the reform proposals of the Executive faced resistance at various levels. The first level involved factions within the Executive itself. This was the case for the economic reforms pursued during most of the eighties. The same situation arose as a reaction to economic liberalization pursued at the outset of the Gaviria administration with major resistance stemming from within the Executive, under the leadership of Ernesto Samper, then serving as Development minister, later to succeed Gaviria as President.

When reform initiatives have to be discussed and approved in Congress, the interaction between the Executive and the legislative body is a complex one, due to the characteristics of the party system in Colombia and the composition of the chambers. Patronage and regional competition for public resources are important incentives in the interaction between these two branches of power. The debate in Congress is further influenced by the low level of party cohesion, which forces the Executive to negotiate with each member of Congress to secure his/her vote for an initiative. This situation also demands an elaborate strategy of party coalition management by the Executive and those policy makers in favor of a particular policy initiative.

Outside Congress, there are other groups that intervene in the process of policy making such as producer associations, unions, think tanks, the media, and particular groups that are affected by policy

decisions. While all may have some degree of influence at certain stages of the policy process, they are mostly vulnerable to the State's agenda due to the lack of representation, fragmentation in their interaction with policy makers, and poor institutional mechanisms to influence policy formulation.

In the case of health reform in the early nineties, the particular political economy context within which its policy process developed, was determinant. On the one hand, in 1991 a National Constituent Assembly (ANC) was elected by popular vote with a mandate to reformulate the Constitution for the first time in more than 100 years. This agenda of major institutional reform was reinforced by an equally comprehensive State reform under the leadership of the Executive and with the support of Congress. Policy reform included opening the country's economy to world market competition as well as labor reform among others. After the ANC, decentralization, education, housing, and social security reforms were to follow.

The implementation of the second-generation reforms—those related to the social sphere—was undertaken during the following administration of President Ernesto Samper. This administration held a different position towards what has been called the modernization strategy. It was also convinced of the need for a consensus strategy around the policy making process and of delaying the pace of the reforms in order to adapt them to the particular circumstances of the country. Also, the Executive's room for maneuver was constrained due to the political difficulties faced both at the national and international level, as a result of political scandals. This situation gave enormous power to Congress and different groups such as unions and economic groups, who were thus not only able to obtain important concessions in salaries and privileges; but were able to affect policy content. It was in this political context that the implementation of the second-generation reforms began, with health reform being no exception.

POLICY PROCESS

The Colombian social security reform, which included health reform, was approved in Law 100 passed in 1993. It was an ambitious and complex transformation that was made during a period of State reform. The process of definition and approval of the reform took three years. Former President Gaviria, under whose government the health reform took place, has stated that it is probably the most important social transformation in Colombia during the second half of this century.¹ However, health reform was not part of his initial policy agenda pertaining to social security reform. Instead, it was the concession the Executive had to make to Congress in order to have the pensions reform approved. However, once the Executive took up the banner for health reform, it was given full political support. Leadership was assigned to Juan Luis Londoño, the minister of Health, and a small, highly-trained team working with him.

Law 100 reflects an international trend in social security reform, but the context, including the formal and informal political institutions and the main actors involved, made it particular to Colombia and its political circumstances in the early nineties. The Law was the result of a debate in which many "policy nodes" were important—the National Constitutional Assembly (January-June 1991); the Social Security Commission established by the new Constitution to define the basic points of a social security project (July-December 1991); the reform formulation (1992); the debate in Congress with its different stages, including commissions, plenary sessions, and the conciliatory process (1993); the drafting of the reform's regulatory body (January-August 1994); the transition decrees (1995); and the implementation process.

¹ Hommes et al., 1994.

Due to the existence of many policy nodes and the conspicuous discussion that the health reform generated around its goals and means, its final content was the combination of different—even antagonistic—positions. However, most of this process of consensus building took place before the reform reached the congressional arena, and required the previous conciliation or disarticulation of positions within the Executive itself. Most of the issues in discussion gravitated around the tension between the opposed ideas of solidarity and efficiency that different groups wanted to see predominate in the new social security system. The final result was the inclusion of both of sets of ideas as the main principles sustaining the reform. This debate was constant from the drafting of the new Constitution until the reform's implementation stage. The other tension present during the whole reform process was over the roles of the public and the private sectors. The reform of the health services redefined the relations between the State, the market, and society. This was reflected in the combination of public and private systems that was finally formulated and is being implemented.

During this process, a small group of policy makers, which we have called the “change team,” was established in the Ministry of Health under the leadership of the Minister. During the reform's formulation, this team had to interact with other actors such as the members of the National Constitutional Assembly and the Social Security Commission; the teams working at the National Planning Department, the ISS and the Ministry of Health; and the unions and think tanks. Nevertheless, when the proposal was presented to the Congress, the Ministry of Health took the lead and this continued until the implementation phase. During the implementation stage, actors that did not have much influence during the previous stages because the process was insulated from them, took a central role. This was the case of health workers, doctors, public health institutions, and territorial authorities.

Other important actors during the whole process were representatives from territorial health authorities, unions, congressmen, medical associations, health experts, private research institutes, health workers, Cooperative Organizations, pre-paid medicine, producer and business associations, pharmaceutical companies, and politicians. But the users of the system, the consumers, were not represented either in the case of the contributory or the subsidized system. Finally, it is important to point out that at the heart of the process remained the change team. This small group of policy makers, under the Minister of Health's direction and with the support of the president, was able to make important contributions to the decision making process involving the health reform.

THE CHANGE TEAM AND OTHER POLITICAL STRATEGIES

The creation and empowerment of a change team in charge of the reform was one of the government's strategies to pursue health reform in Colombia. This change team was able to achieve results because of the particular strategies it used, but also because its work was part of a larger State reform agenda. Another determinant factor was the team's close relationship with the economic change team. While the configuration and empowerment of the health change team was a successful strategy during the formulation stage of the reform process, its usefulness during the legislation stage, and particularly, its effects on the implementation stage have produced mixed results. Thus, the fact that the reform's implementation is still an ongoing process that precludes drawing any firm conclusions, means that the effectiveness of such a strategy remains an open question.

The team's legitimacy came from its academic training and its previous work in government. It was a small group of policy makers, most of them technical, highly trained and with an international background. They saw themselves as apolitical. With few exceptions, none had in mind pursuing a career within government; rather they were attracted by the possibility of inducing tangible policy change. The team's joint expertise was not only in health or economics, but also in communications,

law, and public administration. It worked in isolation from other groups within and outside the health sector, and it was not part of the formal structure of the Ministry of Health.

The change team's ideological stance was in favor of modernization—changing the role of the State in the social sector; promoting the role of the private sector; increasing efficiency; and using mechanisms other than those historically used in the delivery of social services, such as targeting and demand subsidies. In the team's view, the social sector was relevant as an investment in the country's human capital, and in that sense, it was a necessary condition for economic development.

The team did not have a base of political support, nor did it have particular links with any specific groups within or outside the State. Instead, its power stemmed from the support of senior policy makers in core areas of government such as the Presidency, the Finance Ministry, and the Planning Department (vertical networks). It also counted on a network that team members had been building within government during their professional careers with peers in other government agencies (horizontal networks).

This fact gave change team members independence from interest groups, but also vulnerability, since its permanence in power and its capacity to act depended exclusively on the support of its vertical networks. In addition to those vertical and horizontal networks, the team worked in establishing State-society networks with particular groups that would support its reform agenda.

The team's composition, networks, and strategies changed according to the stage the reform was in. During the stage of formulation and legislation, it had contact with different groups involved in the reform. However, during the development of regulation it insulated itself from interest group influence. Isolation was partly the result of time constraints, but also it was a deliberate strategy aimed at retaining control over the reform. While this strategy allowed the team to develop a number of important decrees and to establish the basis for the development of the new actors in a very short period of time, it became an important source of conflict at the moment of implementation.

The team tried to institutionalize policy change through different strategies. The legal one was very important and was materialized in the approval of the Law 100 and its regulatory package. They also worked to change key personnel as well as the structure of the Ministry of Health. They established networks with cooperative personnel already working at the Ministry, tried to convince the group that was going to succeed them of the benefits of the reform and placed some of the team's members within the new group. These strategies were complemented with the approval of significant loans from the World Bank and the IDB and with the formation of a network of renowned international experts that favored the reform. The sustainability and long-term benefits of these strategies will ultimately have to be assessed in the light of the reform's implementation, which is still in process.

The health change team made two crucial decisions during the reform that have had mixed results during the implementation process. First, it decided to formulate a law with general principles that could then be further developed with more precision by the Executive during the formulation of the regulatory body. This strategy facilitated the Law's approval and, at the same time, gave enormous room for maneuver to the health change team during the promulgation of decrees. Nevertheless, this very same space provided by the very general terms of the Law has been used against its underlying principles once the new administration took power and the change team was no longer in control. Secondly, it decided to give priority to the development of the new actors that were to operate under the new system, instead of concentrating on the direct transformation of the old existing ones – which presented great political obstacles. In doing so, the change team thought that the new actors as well as the new allocation of resources would stimulate the transformation of the old ones. However, these expected results have taken longer to materialize, and, at present, the health system is composed of an array of new actors in combination with old ones still operating under very similar lines to those prior to the reform.

I. POLITICAL ECONOMY CONTEXT

To understand the process of health reform which took place during the early nineties in Colombia, it is necessary to describe the country's political system, particularly its policy process, the main arenas for policy making, and the main actors intervening in those events, particularly during recent years. This chapter provides a brief account of the contemporary events of Colombian politics, and describes Colombia's institutional context.² Combining these two elements, it describes the formal and informal rules for political competition, interest representation, and participation that determine the policy-making process. It focuses on the Gaviria administration, since it was during this period that the health reform was initiated. The chapter concludes with a brief description of the Samper administration that followed, during which the first stages of health reform implementation evolved.

INSTITUTIONAL CONTEXT

GOVERNMENT

Colombia is a Republic with a presidential form of government and a three-fold division of power: the Executive, the Legislative, and the Judiciary. One of Colombia's distinctive characteristics is the level of decentralization of power to regions (*departamentos*) and municipalities.

1. *The Horizontal Organization of Government*

The three constitutional powers operate and interact at the national level. Formally, the Executive is in charge of implementing and enforcing the laws approved in Congress, the Legislature is in charge of formulating and issuing laws, and the Judiciary is in responsible for solving non-armed conflicts between individuals, and between an individual and the State. The Executive is headed by the President, who is elected by popular vote and has a four-year mandate with no right to re-election. The next tier is formed by a 16-member cabinet directly appointed by the President. Additionally, the Executive has three administrative departments with the hierarchical level of a ministry. One of them, the National Planning Department (DNP), has seats both in the Council of Ministers and in the National Council for Economic and Social Policy, the two highest decision-making levels for economic and social policy in the country.

The next level of the hierarchy forming the Executive is composed of a large variety of specialized agencies, such as national decentralized agencies, state-owned enterprises, and public financial institutions. All of them formally depend on a ministry or on the National Planning Department, and in spite of enjoying large degrees of autonomy, the ultimate responsibility lies in the head of the sector. Many of these central specialized agencies operate through regional and field offices, which have little or no autonomy and are entirely dependent on central decision-making and funding.

The Congress has two chambers: the Senate and the House of Representatives. The 1991 Constitution gives 97 seats to the Senate whose members are directly elected by popular vote on the basis of a national constituency. A few seats of the Senate are assigned to specific indigenous constituencies.

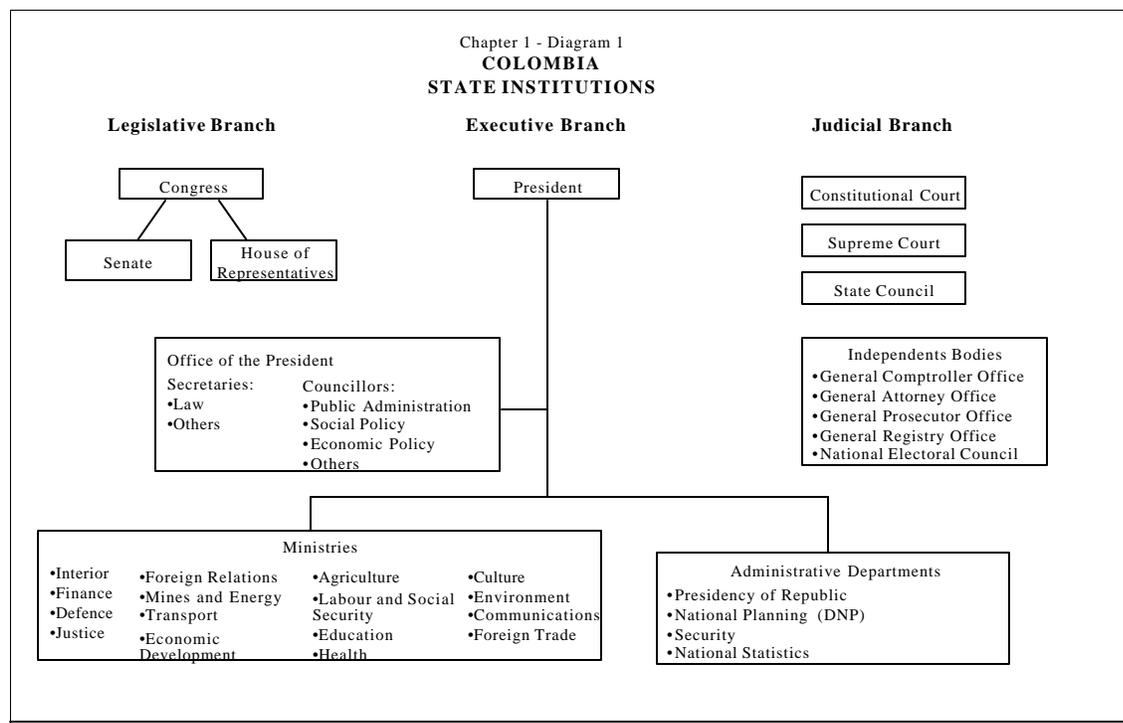
² This chapter was written in collaboration with Manuel Salazar.

The House of Representatives has 145 seats and is also elected by popular vote on the basis of departmental constituencies.³ The electoral system is based on proportional representation, in which voters select a complete list of candidates. The number of lists of candidates presented for election determines the number by which the total number of winning votes is to be divided.

As the number of candidate lists grows, fewer votes are needed to win a seat in Congress. Thus, this scheme facilitates the formation of small clienteles that can elect a member for Congress and increase his chances of being re-elected. This particular scheme benefits the two catch-all traditional parties, since the distribution of seats in Congress according to winning lists, introduces incentives for factionalism, patron-client practices, and the fragmentation of interest representation. However, by the same token, this has also promoted the fragmentation of traditional parties, their increasing lack of a cohesive ideology, and the consolidation of patron-client links as the institutional channels for intermediation between the parties' leadership and their political bases.

The Congress operates on the basis of specialized committees and plenary sessions. Although the latter is the final and highest decision-making level, most of the discussions, debates, bargaining, and logrolling are developed within the committees. With few exceptions, a committee's approval is simply sanctioned in plenary sessions.

Figure 1. Colombia: State Institutions



³ Each department (or region) has the right to a minimum of two members in the Lower House, with additional representatives added according to the department's total population. Two additional seats are assigned to black minorities.

The Judicial branch of power is comprised of four bodies: the Supreme Court, the Constitutional Court, the State Council, and the General Prosecutor's Office. Other institutions at the national level are the General Comptroller's Office, The General Attorney's Office, the National Electoral Council, the National Registry Office, and the National Police.

2. *A Decentralized Government*

The Colombian government is divided into three levels of power: national (central), regional (departmental) and local (municipal). Since the early 1930s, regions and local governments have lost much of their autonomy in a centralization process affecting key regional and local duties, such as infrastructure, housing, education and health infrastructure, water and sewage, and education and health services. Parallel to the expansion of central government, there was a considerable increase in the level of State intervention in economic affairs.⁴

However, while local and regional policy decision making was rendered less and less influential, the party system was entirely based on the organization of local constituencies at the regional and local levels. Party structures were dependent on natural leaders in control of local clienteles. This was further reinforced by the formal institutionalization of interest representation, whereby seats in Congress were defined according to departmental jurisdictions. As a result, while the Executive centralized decision making and control of the national budget, regions were able to continue to exert power and influence over budget allocations in the Congress. In an attempt to secure their level of influence at the regional level, central government agencies decentralized their activities, opening local branches in each region. But these bureaucracies were soon captured by regional constituencies, and were thus also used to increase the regions' control over local policy making.

This tension between formal centralization and informal regional control through party politics reached its peak during the 1960s and 70s, and was reversed during the 1980s and 90's with two radical and comprehensive decentralization reforms. The new Constitution (1991) formally devolves most of the government responsibilities to the regional and local levels, stating that regions are to elect their authorities by popular vote, control their resources, and manage their development process. As a result, half of the total national revenues are currently transferred to local and regional authorities, and most government functions—including health care—have been formally decentralized. While regional and local governments remain dependent on central government resources and decision-making, in spite of these decentralization efforts, they nevertheless exert considerable influence on policy implementation, with health being no exception.

POLITICAL PARTIES

The party system in Colombia is characterized by the predominance of two traditional parties that emerged in the mid-19th century—Liberal and Conservative. They have shared 90% of votes in presidential and congressional elections for the last century. During the last 40 years, a few short-lived movements have been able to control a little over 10% of the votes; and in most cases they have been either a coalition of small parties or a strayed fraction of the two traditional parties. Such was the case with the Revolutionary Liberal Movement in the early 1960s, led by López who became president in 1974 while still belonging to the official Liberal party; and the New Liberalism movement in the early 1980s, led by Galán who later on became the official candidate of the Liberal party in the late 1980s. The National Salvation Movement in the late 1980s and, more recently, the Life Option in the 1998

⁴ For example, there was centralization of monetary and fiscal management in the 1920s and 1930s, rural development programs in the 1940s, establishment of central planning agencies in the 1950s and concentration of policy-making and the budgetary process in the 1960s.

presidential elections, led by Sanín, a female politician who has militated within both traditional parties, are other examples.

It can be argued that there have been only two cases of political movements formed outside the realm of the traditional parties, that were able to accumulate a significant number of votes. The Patriotic Union (UP), the political arm of a guerrilla group (FARC), received enough votes to win a dozen mayoralties and a significant share of seats in Congress in the 1980s. The Democratic Alliance, created by a demobilized guerrilla group (M-19) and led by one of its former leaders, Navarro, obtained a third of the total votes during the 1990 elections. This put them ahead of even the Conservative party, and enabled them to win a dozen seats in Congress. This electoral mandate forced the government to include the movement in the Executive's cabinet, and Navarro was made minister of health precisely at the time when discussions on health reform were starting. Furthermore, the M-19 movement gathered the highest share of votes for the Constitutional Assembly (24%), and thus became a member of its tripartite presidency, and an influential actor in the formulation and approval of the new Constitution. In spite of their popular mandates during the 1990 and 1991 elections, in the 1994 elections both movements eventually lost their political presence. The UP lost all its congressional seats and presented no presidential candidate, and the M-19's Democratic Alliance obtained only one seat in Congress and less than 5% of the votes for president.

Both the Liberal and Conservative parties exhibit a high degree of fragmentation. This is particularly so in the case of the Liberal party, which has been in power for most of this century. It was the Liberal party that, in 1990, introduced a system by which all of its factions—and thus its regional leaders—were able to participate in electoral competitions for congressional seats. By means of this system (called the “wasp operation”), now used by all parties, each regional leader can head a candidacy list, which is presented at the ballot box the day of the election. This approach, coupled with the fact that the greater the number of lists, the fewer votes needed to obtain a seat, has generated an enormous number of lists from which voters need to choose candidates.⁵ This has further deepened party fragmentation, since a party member with his or her own clientele has no incentives to follow party discipline or even its ideology (Shugart, 1992). The Liberal and Conservative parties have been deprived of a cohesive electoral source of support and have been divested of ideological consistency. The party leaders have incentives to approve lists of varied nature in order to obtain as many seats in Congress as possible (Kline, 1995). This has induced the coalescence of multi-party and intra-party political forces without a coherent ideological position.

Such informal rules of interest representation have had considerable consequences for the policy making process. Even though the Executive counts on extensive powers, the Congress maintains a strong veto power. However, its power remains in its reaction to Executive's initiatives, since its fragmentation precludes it from being proactive in policy formulation and legislation. This is due to the difficulty of creating coalitions in support of policy issues, given that there is no party unity. Members of Congress are not accountable for policy results, but for the particular benefits their clienteles may obtain. The Executive is thus forced to build a congressional coalition for each policy initiative it submits for legislation. The willingness and capability of the traditional parties to support an initiative it always uncertain—even in the case of the party in power. In spite of the resulting crisis in interest representation, which has alienated parties from the political needs of the country and excluded large portions of the population from institutional politics, the traditional parties continue to have important electoral capacity and have resisted many challenges (Archer, 1995 and 1997; Hoskyn, 1997).

⁵ This was the case in the 1994 elections. In 1998, the 100 senatorial seats were chosen from a total number of 98 candidacy lists.

OTHER GROUPS IN SOCIETY

Aside from political parties, social groups outside the State have access to the arenas of power and thus are capable of influencing policy making, be it by modifying its outcome or even thwarting the implementation process. Among these groups, some of the most influential are business and producer associations (ANDI, FASECOLDA, ASOBANCARIA, FENALCO, ANIF, and SAC); economic groups (Group Santodomingo, Grupo Ardila Lule, Group Sarmiento, and Carvajal); professional associations including doctors); unions (CUT, FECODE, and USO); think tanks (Fedesarrollo); academic institutions; foundations (FES and the Corona Foundation); and the mass media and opinion leaders, such as former presidents and journalists.

These groups have increased their mobilization and influence since the 1970s and, to a certain extent, have filled the political space left empty by political parties. They have been the most consistent interlocutors of the government—analyzing, doing follow-up, and criticizing public policy decisions. Their power has depended on their level of organization, their resources, the importance of the sector they represent, and their analytical capacity (Sánchez, 1989).

They have sought—and in most cases obtained—access to policy making through informal and semi-institutionalized channels. Their most visible and direct access to policy making is through congressional commissions, or by having some of their members win congressional seats. But in most cases, they resort to their analytical authority and the knowledge and information they can bring to bear on particular policy issues in order to exert their influence in different policy arenas within the political system. While Congress might be the most visible of these arenas, they place a high priority on influencing the Executive, given its importance in the policy making process in Colombia.

Serving this purpose, there are clear informal channels among these social groups and high level decision makers in the Executive, including the president and the ministers, due to the revolving door between government posts and positions in organizations such as producer associations, academia, think tanks, and other private foundations. Formally, there are frequent institutional forums in which government and pressure groups interact. Finally, these groups resort to the mass media and to the courts to present their cases when other channels of access have failed (Bushnel, 1993; Hoskins, 1997).

The degree of access to policy making of these groups is not seriously limited by policy makers attempting to gain or maintain a certain level of autonomy in decision making. The most serious limitations stem from the nature of the groups themselves. They tend to be heterogeneous, fragmented, and with unequal access to the arenas of policy making. In the case of producer associations, which are among the most powerful groups, they lack member representation and in some cases are unable to force their membership to abide by agreements reached with government. Yet, they remain the most influential groups, clearly differentiated from the consumer associations, that have found access to policy decision making more arduous.

Only 7% of the work force in Colombia is unionized, since half the economy is formed of small enterprises mostly in the informal sector. While it can be argued that the union movement is fragmented and weak in the private sector, the same cannot be said of public sector unions, particularly those related to the provision of social services. The latter have a higher degree of influence on the Executive, members of Congress, and the media through their participation in commissions (where they may be formally invited); in public debates; and in other negotiation arenas. But their main means of exerting influence over policy decision making is their capacity to threaten or organize civil strikes to press their interests, which in most cases are related to wages and/or benefits as well as to job security.

The most powerful labor association is the public school teachers union (FECODE), which currently has approximately 250,000 members, has a strong leadership with high representation, and is

very disciplined. Holding some seats in Congress, this union counts among its achievements in confrontation with the State, the “nationalization” of the teachers in 1975,⁶ and the modification of the decentralization and education laws (Laws 60 and 105, 1993) according to their interests. Another union with similar characteristics; i.e., control over the government provision of social services, is the union of health sector workers, although it is much less important in terms of its influence in the policy-making process than the teachers union. The health labor movement is fragmented, with separate unions for hospital workers, medical doctors, nurses, and others, and their actions tend to be isolated.

Outside the social sector, other unions with particular strength are those in strategic sectors, notably the oil workers union of Ecopetrol, the government agency in charge of oil and gas exploration, exploitation, and distribution. Other unions with similar structure and mobilization strategies, are those of truckers and public inter-urban transport among others. Finally, there are a few umbrella organizations, which group together important unions and have strong influence. Such is the case of the Central Unitary Union (CUT), which represents most labor unions; or the Public Sector Workers Union. These unions, particularly the CUT, play an important role in the annual definition of the minimum wage, which takes place in a tripartite government-business-labor committee.

The evolution of the institutional context in Colombia has facilitated the access of the social groups described in this section to policy making. The crisis of interest representation due to party fragmentation and the need of weak governments to sustain their power with the support of heterogeneous coalitions have rendered State autonomy more limited. However, it cannot be argued that there is complete State capture, since the influence of these groups has been limited to the alteration of sector-specific policies and particularly to negotiating or severely limiting policy implementation in their respective sectors. Presidents with a particularly strong mandate have been able to move their policy initiatives forward in spite of this influence.

All of these actors have considerable, but not unlimited capability to influence public policy. The Colombian State, though hardly autonomous, is not managed by any one group or single set of actors. They have exercised their power in particular through influencing affecting sectorial policies, and in thwarting policy implementation. Their access has been favored by the fragmentation of power within party factions, which has enlarged channels of access to arenas of decision making such as different groups within congress or different ministries. Their power has been increased under presidents who have to rely on complex coalitions to be able to maintain their power. Stronger presidents have been able to form cabinets with individuals who shared their policy vision, facilitating a certain degree of autonomy from those pressures (Hartlyn, 1989).

GENERAL FEATURES OF THE POLICY PROCESS

THE LEGISLATIVE PROCESS

Issuing a new law or reforming a standing law is a long process, that may take up to a year during which it may be discussed, bargained over, and eventually approved. A bill in Congress may be initiated in two ways: either by a member (or group of members) or by a Minister or the President on behalf of the Executive. Some bills can only be presented to Congress by the Executive. Among these, are bills in

⁶ Through nationalization teachers were no longer administratively dependent on either departmental or municipal governments, but on the central Ministry of Education. Such a measure was a clear victory for FECODE, given that decentralization of teacher’s administrative management was considered by the union (as well as by the Government) as the fragmentation of FECODE and its consequent undermining.

areas such as the structure of the Executive itself, foreign exchange, foreign trade, taxation, and fiscal matters. The new 1991 Constitution mandated that the Executive be responsible for presenting law initiatives in areas related to a profound State reform, among these, decentralization, budgetary system reform, and health reform. When a bill is registered in Congress it is turned over to a specialized committee in one of the congressional chambers. (Unlike the United States, there is no rule in Colombia as to which of these should discuss a bill first). There, it will be given priority among other bills according to the interests of the legislators' and the government.

It is during this period in the congressional committees that the law initiative suffers its major changes. Political bargaining takes place between the Executive and the Congress, between congressional factions and between the latter and interest groups in society trying to influence the policy process at this stage. Once approved, the bill will be turned over to plenary sessions for further discussion and bargaining, and eventual approval. If the congressional period⁷ in which the bill is presented comes to a close without its approval, it is filed and the process must start again with the presentation of a new initiative⁸. Once approved in one chamber, the bill is sent to the other chamber where it undergoes a similar process. The second chamber to consider the bill may take one of three decisions: approve the law and submit it to the president for his approval (and subsequent issue); introduce substantive changes in the bill and return it to the original chamber for further revision and discussion; or disapprove the law thereby filing it. In the latter case it cannot be presented again in that form.

Given the particularities of interest representation in Colombia described above, political incentives are such that legislators tend to condition their vote on national budgetary allocations and other benefits favoring their regional and local clienteles, instead of basing it on policy content. This has turned Congress into a node where the policy making process is slowed down and even paralyzed (Hartlyn, 1988; 1994, Archer, 1995; 1997). A few exceptions that may speed up the process occur when legislators have a particular interest in the issue—as was the case of health reform—or when they see an opportunity to further their personal political careers. This was the case with the 1980's reforms that had mayors and governors be elected by direct popular vote, and furthered administrative decentralization (Archer, 1995; 1997).

POLICY MAKING AND DECISION-MAKING WITHIN THE EXECUTIVE

In stark contrast with Congress, the Executive branch is the most dynamic policy arena in Colombia's institutional context. It is the source of nearly all of the significant policy formulation, including those initiatives that require legislation. Until the early 1990s, the majority of policy initiatives circumvented Congress, but the extraordinary prerogatives that allowed the Executive to do so were curtailed in the new 1991 Constitution, which tried to re-dress the imbalance between the branches of power. Nevertheless, the Executive still has extensive control over the legislative process, with prerogatives such as being the only formal origin of law initiatives in specific policy areas and having the power to veto legislation issued by Congress. The Executive also has the power to govern by decree.⁹ This is a prerogative bestowed by Congress to issue decrees with the force of law during specific periods and in particular policy areas. In addition, the Executive has the authority to formulate and enforce the regulatory body of the laws approved in Congress. In light of the very general terms in

⁷ Congress is in session twice a year: between March 16th and June 20th and between July 20th and December 16th.

⁸ Actually, the majority of bills end in such a manner.

⁹ Even if limited by the new Constitution, the Executive's power to govern by decree continues to be quite extensive.

which laws are usually passed, drafting the regulations provides the Executive a second window of opportunity to shape the final outcome of its policy initiatives in spite of changes introduced during the bargaining process in Congress. A clear example of this was the development of the regulatory body of Law 100, the health reform. The Executive's leverage over Congress is further reinforced by the lack of technical capacity and political will of most congressmen to assume their formal role in policy making (Acher, 1997).

Within the Executive, the President resorts to both formal and informal mechanisms to reinforce the power vested in him and his control over the workings of the Executive branch. One of the key formal mechanisms is his right to appoint ministers, top- and medium-level government employees, and directors of national decentralized agencies.¹⁰ Among the President's informal mechanisms is the formation of a small team of policy makers who remain very close to him and whose combined technical and political abilities facilitate the formulation and implementation of his policy agenda.

These groups are informal structures within government, more isolated from the political pressures that surround the Executive than other policy makers, and yet in charge of developing policy and political strategies. This group colonizes sectors whose reform is on their agenda, by sending some of their members to lead the reform efforts. Such was the case of social security and health reform in 1993-94. These groups recruit their members based mainly on meritocratic criteria where highly technical training and previous experience in policy reform are important. The location of such a group within the institutional context varies from one administration to another, but invariably includes the Minister of Finance and the Director of the National Planning Department (DNP). Other members of this group may be drawn from different ministries and government agencies, such as the Central Bank and the Office of the President.

These groups will be referred to in this study as "change teams" and they can be identified in different administrations. For instance, the Barco administration had a change team formed by Luis Fernando Alarcón, the Ministry of Finance; María Mercedes Cuellar, the DNP director; and Germán Montoya, the DAPRE director. President Gaviria formed a strong organization within the State—perceived by some observers as a para-State—within the Office of the President that continuously interacted with the Minister of Finance (Hommes), the Director of the DNP (Montenegro), and other key ministries depending on the policy issues. This included Health (Londoño) and Labor for elaborating the social security reform. President Samper relied more on the Ministry of Finance and the Director of the DNP, and less on the Office of the President.

In spite of the power imbalance between the Executive and the Legislative branches of government favoring the first, the Legislative power retains an important veto power. The fragmentation of the political parties and the influence of the regions, with their propensity for rent-seeking behavior, has slowed down policy change initiatives stemming from the Executive, since it is forced to lobby and secure the votes needed to pass legislation at times on an individual basis (Acher, 1997). However, the administration of President Gaviria stands out as an exception to the rule. The social mandate for a thorough political and social reform,¹¹ along with the political maneuvering of the change team that he

¹⁰ With the ANC, Congress gained some control over through the possibility of censorship for those appointments.

¹¹ The Barco administration preceded the Gaviria administration in its attempts at introducing thorough State and political reforms, such as the peace process (and the demobilization of some guerrilla groups) and the formal end to the National Front agreement, decentralization, and major constitutional reforms. These initiatives and their first results unleashed the political pressure for the Gaviria administration to follow and consolidate efforts in that direction. The peace process resulted in the demobilization of four guerrilla groups and their nearly 3,500 militia. There was also pressure to put a formal end to the National Front. The decentralization process provided evidence of the inefficiency of State provision of social services at regional and local levels. Finally, social groups were becoming tired of 15 years of failed attempts at reforming the Constitution.

empowered, were able to have a series of economic and social reforms legislated—some even implemented. One of these reforms was the social security reform, along with its health component.

Within the Executive the highest formal decision-making bodies are the Council of Ministries, which makes decisions on political issues, and the National Council for Social and Economic Policy (CONPES), which makes decisions on social and economic matters. Both bodies are chaired by the President. The Council of Ministries is comprised of the members of the Cabinet and the Director of the National Planning Department. The CONPES is formed by the Ministries of Foreign Relations, Finance, Agriculture, Economic Development, Labor and Social Security, Foreign Trade, Environment and Transportation, the Director of the National Planning Department, the Governor of the Central Bank, the General Manager of the National Coffee Federation, and President's special advisors for economic and social affairs.

As a result of the State reform initiated in the early 1990s, the responsibilities and functions of the CONPES in the social policy area were modified, and these now include aspects such as decentralization, co-finance of social services, social security and health care, among others (Decree 2132, 1992, Art. 26). The National Planning Department (DNP) plays the role of technical secretariat for this body of decision-making, and in that role, it helps prepare all the white papers that are presented by the sector-specific ministries for analysis and discussion. While the existence and activities of this body are not enforced by law, it is here that all policy initiatives in the social sector are presented and discussed within the Executive, and law initiatives to be presented in Congress stem from it. Its power and importance in the policy process depend entirely on the president's support.

In the area of economic policy, the CONPES is also in charge of discussing and approving the government's macroeconomic program, which is prepared by the National Planning Department, the Central Bank, and the Ministry of Finance as well as the budget, which is prepared by the Ministry of Finance and the National Planning Department, before it is sent to Congress for approval.

Once the CONPES has defined the policy guidelines and the budget has been approved, ministries enjoy a high degree of autonomy for policy decision making. This is also true for the national decentralized agencies, which have a large space for maneuver to exercise their mandates. More interestingly, the lack of coordination between these agencies and regional and local level governments presents a serious impediment to implementation of the policy guidelines decided at the central level. The agencies' field offices have little leverage and low decision-making capacity, in spite of having a high degree of influence in the implementation process. This results in very weak coordination between the central, regional, and local governments.

Another factor that greatly undermines the Executive's capacity to promote policy initiatives is the high degree of circulation in top positions at the ministerial level. This is particularly conspicuous in the social sector ministries that are not as strategic as the Finance Ministry and the Planning Department, and are therefore used by the President for political purposes, such as maintaining his coalition of support among party factions Hartlyn (1994). The weaker the government in power, the higher the degree of circulation and, as a consequence, the higher the level of State paralysis in policy making.

A BRIEF ACCOUNT OF POLITICS IN COLOMBIA SINCE THE 1950S

The events of the 1950s mark an important turn in Colombian political history, and are at the core of contemporary politics and policy making. After a period of great political violence and State decomposition interspersed by a brief military regime, the political elite in Colombia established an accord that sought to end violence and establish the rules for power-sharing among the two traditional

parties—Liberal and Conservative. This new form of institutionalization was called the National Front and it changed dramatically not only the rules of political competition, but policy decision making in all branches of power ever since. Although the National Front was formally ended in 1974, its *modus operandi* permeates policy making until the present day.

THE NATIONAL FRONT (1958-86)

1. *The Political System*

During the 1940s and 1950s Colombia suffered a period of violence between adherents of the two traditional parties, which left more than 200,000 deaths and led to the imposition in 1953 of a military regime. In order to restore civilian rule and end the violence, a bipartisan coalition formed by the leaders of the Liberal and Conservative parties was established in 1958, called the National Front. The National Front introduced the alternation of these parties at the presidential level every eight years by having only one party at a time nominate a presidential candidate during electoral periods. At all the other levels of government as well as in the Congress, power was to be shared on an equal basis, which meant that each party was guaranteed fifty percent of the posts across the State from the national to the local levels of governments. Each party was also guaranteed half of the congressional seats. Power sharing was furthered by requiring a two-thirds majority in Congress for a new law's approval.

The National Front achieved its goals in the short term by restoring civilian rule in 1958, and ending inter-party violence in the following decade. However, it generated a series of side effects for politics and policy making in Colombia. The resulting barriers for the participation of other parties and political groups, not only further debased the incentives for competition, but, most importantly, severely limited political participation and interest representation. This was the case of the Revolutionary Liberal Movement, who in spite of obtaining a significant number of votes for Congress, was excluded in the 1960s. The opportunities for institutional competition among social groups with different ideological and political positions were rendered null. This created the conditions for the re-emergence of violence, although this time not among the traditional parties, but rather from social groups excluded from political competition against the State. Both the FARC and the ELN, the two strongest guerrilla groups, emerged in the mid-1960s, and gained strength in the following decades.

Due to the increasing loss of ideological differentiation among the two parties due to the lack of competition, clientelism and the distribution of government posts were soon substituted for party discipline and the discussion of policy platforms. As a result of the absence of ideological differentiation and real competition among the two traditional parties, "growing electoral and systemic alienation appeared, as the average of Colombians (sic) understood the futility of active involvement in politics" (Martz, 1992:29). Abstentions increased from 42% in 1958, to 60% by 1978 in the case of presidential elections; and from 31% in 1958 to 67% in 1978 for congressional elections (Hartlyn, 1988). The political elite responded to this vacuum of interest in participation by expanding its clientelistic network, but did not lower the entry barriers to other political forces (Leal, 1989). Nor did this have any ameliorative impact on its policy offerings.

The need for a two-thirds majority in a bipartisan Congress generated the incentives for coalition building and voting on an individual basis, rather than along party lines. Power sharing brought the role of the opposition to an end, and policy debate among political parties was merely rhetorical. Legislators tried to secure re-election not by studying and debating policy initiatives, but by conditioning their vote on the allocation of public resources and benefits to their regional political bases and the control over a certain number of government posts with the same purpose. This, in turn, promoted the emergence of regional and local leaders whose careers were not based in their ideological or programmatic fit with the traditional parties, but rather their ability to control a clientele

by obtaining public resources and benefits. The political elite at the national level reacted by centralizing decision making in the party conventions, where national leaders took the important decisions and elected the presidential candidate.

A constitutional reform in 1968 formally sought to end the National Front accord by 1974, at which time political competition was to be reintroduced at the Executive and Legislative branches, as well as regional and local elections. It also reduced the number of issues requiring a two-thirds majority in Congress for legislation. However, it continued to offer a basis for the continuation of coalition rule. Furthermore, the two party rotation for the presidency, even if formally terminated, was maintained until 1978, and the distribution of government posts among the two parties on an equal basis was to continue, with one short-lived exception until 1986.¹² The government by coalition continued with the same embedded practices through the 1970s and early 1980s (Hartlyn, 1988; Leal, 1989; Dix, 1987; Kline, 1995).

2. Policy Making and Planning Processes

As a response to the policy immobility generated by the political arrangement described above, in 1968, the government of president Lleras Restrepo promoted a constitutional amendment geared at strengthening the Executive's power, with particular emphasis on the President's control over economic policy (Hartlyn, 1994; Archer, 1997). In order to increase the Executive's command over the economic sector, monetary and fiscal policies were centralized and taken away from congressional intervention. Also, control over the budget and foreign trade was re-taken by the Executive requiring the approval of the Finance Ministry and the DNP, instead of that of Congress.

Heavily influenced by the international trend, which was being promoted by development agencies, the Lleras Restrepo administration also aimed at strengthening State intervention and the centralization of policy decision making and planning. It also aimed at the professionalization of the bureaucracy in key areas of government, as well as the rationalization of policy making, by basing it in technical assessments of policy and public investment projects. This prompted the formation and recruitment of a technocratic work force in decision-making positions within the State that was to be the precursor of the technocratic teams of the 1980s and 1990s. Two central policy making bodies were strengthened along these lines within the Executive. One was the Economic and Social National Council, chaired by the president, which was to become the highest level of policy decision making. The other was the National Planning Department, which was put in charge of the national development plan and, along with the Finance Ministry, of the public annual budget. All decisions related to the national budget, including budget allocations to the different ministries and national agencies, were put under the joint responsibility of the Finance Ministry and the National Planning Department.

For the sake of improving and rationalizing policy making, a particular effort was made to isolate these two government agencies from party politics and the clientelistic network that had taken control of all realms of the political system. Two key positions, Finance Minister and Director of the National Planning Department, were no longer subject to political bargaining and they were assigned to technical professionals who were close to the president. The assignment of these two policy makers tended to be stable and the high level of circulation that permeated the other ministries was avoided.

The recruitment of policy makers for both agencies was made among highly trained technical professionals, mostly economists, who did not have previous political experience. This effort started a trend in which the government became the principal recruiter of the economists with graduate studies in important universities in the United State and Europe for the following thirty years.

¹² The Turbay government (1978-82).

This strategy was to play an important part in Colombia's economic performance during that same period of time since it successfully limited the political use of economic policy and provided the State with the capacity to manage the increasingly complex economic policy.¹³ As a result, the Ministry of Finance, the National Planning Department, the Central Bank, and the Office of the President were soon to become a core group of agencies that provided the source and support of State reform and policy change initiatives in the following decades. This included the health reform.

The expansion of the central level's control over national policy making was another feature of this effort to regain dominion over policy making. More than 60 central agencies were created during the 1960s and 1970s (Bird, 1984) putting under central control policy responsibilities previously in the hands of regional and local governments, such as water supply and sewage, health, and education. Simultaneously, the government promoted the decentralization of these agencies to regional and field offices under the control of the central government with no formal link to regional and local authorities, whose functions were displaced.

In the early 1970s, as a consequence of this centralization process, health and education became the sole responsibility of the federal government, a process that came to be called the "nationalization" of health and education. From then onwards, teachers and health workers became civil servants under the jurisdiction of the national level of government.¹⁴ Tax revenue resources (*Situado Fiscal*) for primary education and health services were allocated to the different departments, but it was the regional offices of the ministries of health and education who received and managed such resources, with no participation by regional authorities.

THE POST-NATIONAL FRONT PERIOD (1986-90)

1. *The Barco Government*

The arrival of President Barco to power marks a turn in the contemporary political and policy history of Colombia, since it was during his administration that the precedents of the current state of affairs in politics and policy making were set. His profile is different from that of his predecessors in that he had a highly technical background to go with his experience in politics, including experience gained by his exposure to the international arena. He had studied engineering in Colombia and had post-graduate studies in MIT. He had occupied technical ministries such as public works and agriculture and he had a broad international experience in Washington as director for Colombia in the World Bank and in London as ambassador. Barco had also actively participated in politics. He was a member of Congress for more than twenty years and had his political base outside the capital. He had served as mayor of Bogotá.

The Barco administration (1986-1990) attempted to change the political rules of the game and introduced major State and economic reforms. Although these reform efforts were not to be consolidated during his administration, they provided the basis for the period of major reforms that were to follow in the 1990s in the economic and social sectors. He considered technical expertise as a condition for State performance, and thus was the first to empower policy makers with high technical skills and entrust them with the formulation and implementation of the public agenda in several fields. He also systematically attempted to bridge the gap between this new breed of policy makers and politicians, although he was not always successful in his endeavor.

¹³ Colombia's economic growth averaged four points during the 1970s and 1980s and avoided the cycles of depression and hyperinflation that were common in the other Latin American countries during that period.

¹⁴ A policy reform that was supported by the education and health unions since it facilitated their unification in one central and national body, thus strengthening their negotiating power *vis a vis* the State.

The Barco administration was the first single-party government since the 1940s, as a result of the Conservative party's refusal to participate in a coalition government that would have reflected electoral results. This would have given the conservatives only 35% of the government positions, instead of automatically assigning it half of the government's posts. This was seen as the end of the coalition governments established by the National Front accord, which had formally ended in 1974. It provided an opportunity for the return of more disciplined parties with clear ideological profiles and separate policy platforms resulting from the newly invigorated need for party competition (Hartlyn, 1988; Bushnell, 1993; Kline, 1995; Dix, 1989; Cepeda, 1994; Hoskin, 1990).

1.1. Elections, Government, and Congress

President Barco did try to depart from the traditional coalition government arrangement by presenting his candidacy as a truly Liberal platform with little space for the Conservative agenda. This was a stark difference from the previous conservative government that incorporated the agenda and the members of the Liberal party in a traditional coalition government. The resulting party unity along with the weakness¹⁵ and the lack of support for the departing conservative government¹⁶, gave the Liberal Party a stark majority (58%, *vis a vis* the Conservative Party, which obtained 34% of the votes).

But party unity for electoral purposes was not to be sustained once the Liberal party was in power. In fact, during that period, the government's party lack of discipline presented the most formidable obstacle for the State to pursue policy change. The government received serious criticism from its own ranks—particularly in Congress—from members eager to pursue their political careers by differentiating themselves and/or their factions, instead of via party discipline. At the same time, the Conservative Party did not assume its role as an opposition party in the policy debate or present itself as a serious alternative to the party in power. Instead, it maintained a rhetoric of systematic criticism of the government in power (Hoskin, 1994). The ideology of both parties remained unclear.

In spite of politicians' resistance from within and outside the party, President Barco pursued his efforts to modernize the State. For that purpose he empowered a group of technocrats whose power depended exclusively on his political support. They occupied the core positions in government—Finance, Planning, the Central Bank, and the Office of the President—and became the government's spokesmen, particularly in Congress. Their technical, apolitical discourse and their lack of experience at political maneuvering created serious tension between the Executive and Congress, and President Barco had to reshuffle its cabinet in order to protect his technocratic team.

In the political arena, the most important impediment to the consolidation of single party governments and the establishment of rules that would allow Colombia to move away from the National Front coalition government arrangement, was Congressional politics. Neither party was interested in sanctioning rules that would reform the *status quo* based on coalition government, since this system had guaranteed both traditional parties the control over a certain number of electoral positions plus government posts (Hartlyn, 1988). Nor was either party interested in policy making and debate in Congress, since the political incentives that favored clientelism and pork barrel were still present and provided greater possibilities for re-election.

¹⁵ Betancourt had arrived to power as a result of a deep division in the Labor party ranks. One of the two competing Liberal leaders, who together obtained more votes than the Conservative candidate, was Galán. Galán had questioned the elitist selection of party candidates and had presented an agenda of State reform and economic liberalization that was to convert him in an important national leader.

¹⁶ Due to the effects of the Latin American economic crisis, which were being felt at the time, and the Betancourt government's mismanagement of the political crisis generated by the M-19 guerrilla group's invasion of the Palace of Justice, which ended in a massacre.

1.2. Barco's Policy Making

The Barco administration managed to introduce key State reforms. It legislated and implemented the first major decentralization effort, which devolved the management responsibility of a series of public goods and services to local governments. Such was the case of water and sewerage, local infrastructure, urban and rural electricity, rural extension services, infrastructure for primary education and health, urban public services and urban planning, among others. This was accompanied by the reallocation of resources in the form of intergovernmental transfers and an increase of the share of the value-added-tax to be transferred directly to municipal governments with 45 % earmarked for social services and infrastructure.

In the political arena, it passed a constitutional amendment by which mayors were to be elected by popular vote in local elections, and were to assume executive responsibilities as heads of local governments. This endowed local governments with greater autonomy and limited the center's influence over local policy making. Other measures geared at enhancing community participation were the establishment of the practice of referendums for decision making on key issues, the direct election of local administrative boards (community bodies with Executive-delegated functions) as well as other measures supporting local participation in public service provision.

Along the same lines, Law 10, passed in 1990, was to reorganize government functions within the health sector granting municipalities responsibility over primary health care as well as first-level hospitals and health centers. The same law assigned responsibility for second-level hospitals to departmental governments, as well as the coordination of health campaigns. The central government was left the responsibility of policy formulation, the establishment of national minimum health standards, and the management of third-level hospitals. Central institutions were either reformed, as was the case of the Ministry of Health, or dismantled, as was the case of the National Hospital Fund and the National Health Institute, which was converted into a research institute.

In the economic arena, the Barco administration introduced the strategy of modernization and internationalization of the economy. Since its approval was achieved during the last year of the administration, only a few measures were implemented such as lowering import tariffs, but this effort set in motion Colombia's economic reform that took place during the following administration. Of particular relevance is the fact that for the first time, this reform was conducted by a small group of technocratic policy makers close to Barco, who thus formed an economic change team. The economic reform's policy formulation—the white paper—as well as the first steps towards implementation were put in the hands of this team comprised of a few Ministers and presidential advisors with strong technical skills, who had been part of the Barco government since his arrival in power. The team was formed by María Mercedes Cuellar, Minister of Economic Development (previously director of the DNP during Barco's government); Luis Fernando Alarcón, Minister of Finance; Luis Bernardo Flórez, Director of the National Planning Department (previously Finance Vice Minister and Deputy Director of DNP also under the Barco administration); and the Directors of the Central Bank and the Administrative Department of the Presidency.

During his administration, President Barco attempted a thorough constitutional reform and proposed a plebiscite. But both initiatives were rejected by the traditional parties. During the 1990 congressional elections, a student-led movement forced the insertion of an additional ballot asking voters whether or not they wanted a constitutional reform. The "yes" vote won an overwhelming majority of more than 90%, and thus Colombian society expressed a clear mandate for constitutional reform. This mandate was endorsed with a formal referendum organized to coincide with presidential elections two months later, which obtained similar results, and led to the National Constitutional Assembly during the following administration.

During the peace process in which it sought to end the armed conflict with several guerrilla movements and to incorporate them to institutional political competition, the Barco administration acted on two fronts. On the one hand, it implemented the National Rehabilitation Plan (PNR), geared at reinforcing the State's presence through higher federal budget allocations, in areas with high levels of guerrilla conflict, which comprised a third of the total municipalities. On the other, it implemented a peace process with guerrilla groups who were small in size, but which had historical and symbolic importance. These groups included the M-19, the Popular Liberation Army (EPL), the Quintín Lame Indigenous Movement and the Workers Revolutionary Party (PRT). As a result, approximately 3,500 militia were demobilized, and joined two new institutional political movements: the Democratic Alliance—the political arm of the demobilized M-19, which presented a presidential candidate in the 1990 elections—and the Hope, Peace and Freedom movement, the political arm of the demobilized EPL. Both political movements were to have a significant role in the political dynamics of the following years, before their presence in the political spectrum was later reduced to a minimum level.

THE GAVIRIA ADMINISTRATION (1990-94)

ELECTORAL PROCESS AND GOVERNMENT FORMATION

In 1990, César Gaviria became the youngest president of Colombia at the age of 43. His arrival to power at that time can be considered somewhat fortuitous, since Gaviria was the campaign coordinator of the Liberal party's presidential candidate and most likely winner, Luis Carlos Galán, when the latter was assassinated by the drug cartels. Gaviria counted on the support of President Barco in whose administration he was Chief of Staff for several years until joining Galán's campaign. Gaviria was seen more as a technocrat than as a politician, but during his administration he was to prove that he had sufficient political skills to empower and support a group of very young technocrats who were to pursue major State and economic reforms.

The Gaviria administration departs from any previous governments in many aspects. Gaviria formed the first echelons of his governments with a young—averaging in their early thirties—generation of highly technical professionals with little previous experience in politics. Only a few members of his cabinet were drawn from the ranks of the traditional party elite. He appointed the ex-guerrilla leader of the former M-19 group, now Democratic Alliance movement, Navarro, as Minister of Health. Navarro, in turn, appointed many of his rank and file to positions in the Ministry of Health. Gaviria also appointed civilians in posts historically assigned to the military, such as the Ministry of Defense, and the DAS.

Gaviria called his term in office the "*Revolcón*," a term referring to the number and depth of policy changes in his policy agenda. Both outsiders and insiders perceived the administration as one in which the technocracy with few links to the political elite, had taken over and used the opportunity to bring about major changes. He has been characterized as a "technopol," a technocrat with political skills (Dominguez, 1997), having a similar profile as that of Carlos Lleras Restrepo and Virgilio Barco, the two former Presidents credited with implementing State reform and modernization, and associated more with a technocratic approach to policy making, as opposed to a political one. Gaviria and his close team were economists with post-graduate degrees mostly obtained abroad. Nevertheless, he had enough political skills to secure the support of former Galán followers who were also in favor of major reform, as well as that of the traditional leaders of the Liberal party.

Gaviria's platform focused on furthering the economic liberalization initiated by the Barco administration, and furthering the modernization of the economy and the government along the lines of Galán's campaign. Since the early stages of his campaign, Gaviria gathered a group of professionals, mostly

academics and researchers, and put them in charge of drafting a project of structural reform that was to be ready to be implemented if and when he won the elections. The members of this group, known as the Club Suizo after the restaurant they used for their meetings, were also characterized as "technopols" (Cepeda, 1995). They were economists who had been working in the Galán campaign, as well as some working in the Gaviria campaign. Upon assuming power, Gaviria appointed many of them to key government positions. Such was the case of Rudolph Hommes, who was appointed Minister of Finance and Armando Montengro, appointed Director of the National Planning Department, among others. Both can be considered core members of the economic change team of the Gaviria administration.

Following the referendum that mandated a constitutional reform, the Gaviria administration presented the legislative initiatives needed to elect and form the National Constituency Assembly (ANC), and pressed the Supreme Court to back it. As part of the peace process initiated by President Barco, President Gaviria granted a seat in the ANC to every guerrilla group that would accept demobilization and join the institutional political competition by signing the peace agreement. As a result, members of the EPL, PRT, and Quintin Lame took formal seats in the ANC.

THE FIRST STRUCTURAL REFORMS

The Gaviria administration set out to implement a radical reform in Colombia's institutional context, the State and the economy. It should be noted that the economic reform was not set in motion as a response to a perceived economic crisis. Instead, it sought to increase economic growth through economic liberalization with particular emphasis on trade and labor. The depth and scope of the economic reform agenda was unusual for a country that had oriented economic management towards continuity of economic policy. President Gaviria's economic reform was based on market liberalization, privatization, and the modernization and internationalization of the economy. This led general opinion to characterize the government as neo-liberal. The government policy had three main goals, that were later backed by the new 1991 Constitution. The first was to improve the economy's competitiveness through market liberalization and lowering trade barriers. The second was to improve government efficiency through the decentralization of government functions and resources according to the comparative advantages of the three government tiers, and the privatization of State-owned enterprises. The third was to boost local government autonomy by increasing its realm of policy decision-making, service delivery capacity and responsibilities, and increasing the allocation of financial resources to the local level (DNP, 1991).

The government's strategy was to present an initial package of structural reforms designed by the Executive, particularly by the economic change team, and have them approved by in Congress. This first set of reform initiatives included the exchange-rate regime (Law 9, 1991 (January)); foreign trade (Law 7, 1991 (January)); financial matters (Law 45, 1990 (December)); taxation reform (Law 49, 1990 (December)); harbor privatization (Law 1, 1990 (January)); labor regime (Law 50, 1990 (December)); housing subsidies and finance (Law 3, 1990 (January)); and government indebtedness (Law 51, 1990 (December)). This set was completed with a series of policy initiatives that were presented as presidential decrees, as was the case of foreign investment and the compulsory institutional investment regime. The preparation and approval of such radical reforms in an unusually short period of time (one legislative session; i.e., less than six months), was the result of the strategy used to prepare the bills, the type of government formation, the Congress' responsiveness to the government's policy initiatives, and the political process leading to the ANC.

As in the case of the Barco reform, the group working on these reforms was small and relatively isolated from bureaucratic pressure. This group included the Minister of Finance, the Director of the National Planning Department, and a group of presidential advisors, most of them working at the President's Office. The economic change team started formulating these policy initiatives before the

President took office, thus securing the possibility of presenting them for legislation on record time. During this process of policy formulation that continued after Gaviria had taken office, the strongest opposition to Gaviria's reform agenda stemmed from within the Executive, particularly from the minister of Economic Development, Ernesto Samper. Samper was a Liberal party pre-candidate who had joined Gaviria's campaign and was later to succeed him as President. He led another group of economists¹⁷ who, although not against economic liberalization in principle, did criticize the pace and depth at which Gaviria's economic change team was planning it. This prompted a long and serious struggle between the two government factions, which eventually needed the direct intervention of the president. The result was a partial compromise between both positions, although the economic change team supported by Gaviria generally prevailed.

The economic change team's liberalization initiative counted on the backing of multilateral agencies, such as the World Bank, that had been promoting it for the last decade. The export sector in Colombia was another important source of political support. There was also a consensus among politicians, technocrats, and some producer groups, that non-traditional exports were also a potential source of economic growth and that their promotion had to be accompanied by import liberalization. This common view was also shared by universities and think tanks, which was an important factor, since the academia had credibility and counted among its members many former policy makers with different degrees of political influence. The Executive implemented the trade liberalization policy on its own, since Congress had given it the prerogative of modifying tariff and non-tariff trade barriers. This process, initiated successfully by president Barco after previous failed attempts in other administrations was accelerated in 1991, and the tariff reduction plan for 1991-1994 was set in motion.

The speed at which trade liberalization was implemented also responded to president Gaviria's concern about the political costs of a protracted process. Furthermore, the organization of the ANC, which was taking place simultaneously, took public attention away from the economic sphere, and made it focus on the political arena. The drug cartel crisis and the guerrilla issues also focused public opinion. In addition, congressional activities were halted during this period in response to an ANC demand that congressional elections be called in accord with the new rules established by the ANC. Notably, the first debate when congressional sessions were re-established was on the economic liberalization process and there emerged strong opposition to the measures being taken. But, since opinion polls were showing that the electorate backed the Executive's policy and thus there were no political incentives to further the debate, the Executive moved on with the liberalization schedule as planned (Urrutia, 1996).

Most of the other reforms on the Executive's agenda needed to have congressional approval, as was the case of the exchange and taxation reforms, among others. A particularly controversial one was the labor reform. President Gaviria was committed to labor reform and was ready to present it to Congress as soon as he took office (Urrutia, 1996). Congress had a tradition of impeding any initiative that could diminish labor rights, but the universities played an important role in portraying levels of unemployment and job instability as a the direct result of labor rights in the current legislation. Another crucial contextual factor that helped the political feasibility of having the new labor law approved was the fact that it was the last initiative to be debated in Congress before it closed to give way to the ANC. Legislators needed to recuperate their lost credibility and prove that they could be an efficient institution that did not need major reform. Thus, the labor reform was approved in spite of organized labor's opposition.¹⁸

¹⁷ As in the case of Gaviria's team, Samper was backed by a technocratic team, led by Ocampo (a PhD in Economics from Yale University and previous Director of Fedesarrollo, the most important center of economic studies in Colombia). It included Florez, Barco's previous Director of the National Planning Department and Guillermo Perry (a former Ministry of Energy and Ph.D. in Economics).

¹⁸ The labor movement had lost political power to maintain the *status quo* as a result of the ANC process and society's mandate for in-depth change.

The legislation process of the labor reform set two important precedents for the social security reform, which included the pension and health reforms. First, Senator Alvaro Uribe Vélez was assigned the presentation of the labor law initiative in Congress, and he was assigned the same responsibility in the social security law initiative. In this capacity, he played a key role in facilitating the approval of both laws. Second, as part of the labor reform initiative package, the Executive asked Congress for the prerogative to reform social security by presidential decree (Botero, Lora, Uribe, 1991). This was denied by Congress, and thus the Executive was forced to face a newly empowered Congress as a key policy node in a more complex political context after the ANC.

The reform agenda of President Gaviria and his economic change team was geared at integrating Colombia's economy into the world markets, and to modernize its institutions. Their aim was not to reduce the State, but to redefine its role. Rudolph Hommes, the Minister of Finance and one of the key figures of the economic change team, thought that the main means to promote economic growth were trade liberalization and opening the economy to the world markets. Strongly influenced by the international economic literature, he believed that economic growth could be achieved through macro-stability, distribution, investment in human capital, elimination of price distortions, introduction of new technology, competitive costs of capital, and more flexible labor and financial markets (Hommes, 1994). Montenegro, the DNP director, promoted a drastic change in the roles of the State and the market. He endorsed private sector involvement in areas previously held as the exclusive responsibility of the State, such as public utilities, social services, and infrastructure; and supported the strengthening of the State's role in areas such as security, justice, and public and social services for the poor (Montenegro, 1997). The health reform that was later to be implemented reflected these ideological positions. The economic change team saw in the social security reform the opportunity to introduce competition and to break public monopolies in this sector, by introducing private sector agencies as health service articulators and providers, and by having public sector institutions compete with other actors in the provision of services and the affiliation of beneficiaries.

In spite of the emphasis on the technical aspects of their policy initiatives, President Gaviria and his change team were aware of the political implications of their reform agenda. According to Montenegro, the DNP director, their reform agenda was aimed at trying to dismantle the model of elitist pluralism that had led to the State's capture by important business groups. This, he argued, had resulted in public policies responding to particular interests, high protectionism, State inefficiency, and the inability to pursue policy change (Montenegro, 1997). This position was backed by Hommes, the Finance minister, who had an open confrontation with one of the most powerful economic groups in the country, Grupo Santodomingo.

In relation to the social sector, the economic change team saw the sector's relevance in terms of investment in the country's human capital, but saw its institutional organization as a welfare-oriented apparatus, which was extremely politicized. They therefore thought that new mechanisms and institutional changes should be introduced in order to promote efficiency through targeting, decentralization, demand subsidies, and the involvement of the private sector in the provision of services. Budgetary allocations for the social sector during this period were not diminished, but actual expenditure and implementation were delayed in part by the requirements of the new Constitution for institutional change (Consejería Presidencial para la Política Social, 1994).

THE 1991 NATIONAL CONSTITUTIONAL ASSEMBLY (ANC)

In 1991, in the middle of the Gaviria administration, the National Constitutional Assembly (ANC) was elected and started to operate. Its mandate was to draft a new Constitution that was to respond to the political needs and aspirations of Colombian society of the 1990s. The 1886 Constitution and its subsequent amendments, particularly those adopted in 1958 and in 1968, were based on the

assumption that the political horizon in Colombia was exclusively composed of two catch-all political parties. The peace process that was started in the mid-1980s aiming at ending the guerrilla war, recognized the need to open the political institutions to other forces and groups who were excluded from institutional competition and representation. Since 1968, there had been several failed attempts to undertake a constitutional reform; notably in 1997 during the Lopez administration, in 1981 during the Turbay administration, and in 1988 and 1989 during the Barco administration. It was the failed efforts of the Barco administration, along with the increase in violence and the serious social and political crisis perceived by society, that finally triggered its mobilization in demand for a constitutional reform, even if what this meant and how to do it remained quite unclear. It was a student-led movement with the support of President Barco and Gaviria, then Interior minister, that called for a referendum, which resulted in a mandate to call a National Constitutional Assembly in order to draft a new constitution.

The ANC was composed of 70 members, who were elected according to a national constituency instead of the regional districts that determined congressional candidates. Members of the ANC could not be legislators, nor could they hold positions in government at that moment. They were also barred from presenting their candidacies for the first congressional elections after the ANC. The profile and configuration of the ANC was a radical departure from the coalition scheme that characterized previous legislatures during the last three decades. Its composition was a result of a series of political events that had taken place during the Barco administration. It was particularly influenced by the long peace process that had started in the mid 1980s, and that was yielding its first results by having certain guerrilla groups demobilize their armed movements and join the institutional mechanisms of political participation (ADM19 and the EPL, in addition to the Patriotic Union, which had been formed as the political branch of an active guerrilla group -FARC). These groups' reincorporation into institutional politics was endorsed by Colombians, who rewarded them by giving them the largest share of votes a third political force had achieved in decades.

Also, in the late 1980s the division of the Conservative party led to the creation of a multi-party movement, with the emergence of the National Salvation Movement. This movement attracted membership from both traditional parties and gathered enough political support to obtain second place in the 1990 elections, a far better showing than the official Conservative party, which only obtained fourth place. As a result, for the first time in the twentieth Century, the two traditional parties lost their absolute majority in the elections for Congress, President, and the National Constitutional Assembly.

Another interesting phenomenon surrounding the ANC was the withdrawal of most politicians of both traditional parties from participating in the process due to a combination of the election rules and an attempt to debase the process. This allowed new leadership to surface and gain a voice for the first time at the national level. In fact, the traditional politicians from both parties, who had been elected eight months before as members of Congress, Mayors, local Councilors, and departmental authorities did not compete for seats in the ANC. Furthermore, the ANC was seen by most of them as a threat to the newly-elected Congress¹⁹ (Cepeda, 1994). The retreat of most of these traditional politicians, along with their local leaders and party machinery, diminished the incidence of clientelistic practices (Acher, 1995). But it also reduced electoral turnout to a record minimum (less than 30%).

In a radical departure from the elite decision-making process of the last thirty years, the ANC gave voice to new parties and movements that could participate and present policy proposals on an equal

¹⁹ And with some reason, since once the Supreme Court sanctioned the results of the National Constitutional Assembly and mandated that they should not be altered by Congressional or Executive decree, there was a serious proposal by a group of independent ANC members that Congress should be closed and new elections called once the ANC finished its activities.

basis with the traditional parties. However, the high level of factionalism in the traditional parties along with the presence of the new movements, limited the scope and number of agreements on reforms that could be reached at the ANC. A number of key aspects were left unresolved, and by default remained in the hands of Congress and the Executive. Among these were the budgetary allocations to the different levels of government and the social security reform (Salazar, 1997).

The National Constitutional Assembly issued a comprehensive new Constitution that involved a radical institutional reform as well as reforms in the political, economic, and social spheres. The institutional reforms included, among others, the reform of the Judiciary and the Congressional branches. It focused on reducing clientelism and improving the transparency of the political process as well as diminishing vote buying. For this purpose, it mandated the dismissal of Congress in August 1991, and new congressional elections later on that same year. Other measures included the democratic election of departmental governors, new measures geared at increasing political participation, and community participation in local affairs, as well as an electoral reform.

In the social and economic spheres, the package of policy reforms that were presented by the Gaviria government to Congress before the ANC, was ratified, and joined another series of policy reforms, including social security, public services, education system, higher education, the provision of electricity, the services regime, economic and social planning, the budgetary process, financial regulation, central bank, intergovernmental transfers and decentralization, telecommunications, civil service, the transportation sector and public works, and territorial organization.

For the majority of these policy reforms, the ANC presented a general framework and, in some cases, a series of guiding principles. This left the actual formulation of the policy details to the Executive and Congress. This granted both the Executive and Congress a large scope of maneuver to define the final contents and direction of the policy reforms. Also, the new Constitution dictated that the Executive would have one year to prepare the details of the policy initiatives and present them to Congress, and that Congress would have one session to take up the initiatives. This contributed to the speeding up of the reform process in several fields, including that of health.

POLITICS AFTER THE ANC AND THE REMAINING STRUCTURAL REFORMS

Responding to the ANC's schedule requirements, and following its own style of policy making, the Gaviria administration set out to prepare the series of policy initiatives to be presented in Congress in areas such as social security, education, transportation, sub-national governments regime, decentralization and grants system, the budgetary process, and others. For this purpose, the government created a series of change teams integrated by officials from the relevant ministries according to the policy initiative. For all policy proposals being prepared, the Finance Ministry and the National Planning Department headed the policy formulation process. Officials from the Ministries of Health and Labor formed the change team for the social security reform, the Presidential Councilor participated with others in the team for territorial organization, decentralization and the grants system, the Ministry of Transport in the transportation bill. This strategy was successful in streamlining the decision-process within the Executive, and made it more expeditious. However, the legislative process to approve this package of policy proposals was going to prove much slower than the approval of the first package of reforms presented to Congress before the ANC.

Although all measures for improving transparency in the political process were carried out for the Congressional elections in October 1991, nearly 50 percent of the elected legislators had also been members of the Congress prior to the ANC. Factionalism and fragmentation remained virtually the same, and the practice of multiple candidacies actually increased. The fragile unity of the newly emerged political forces (AD and NSM) was broken. The influence of unions, interest groups, and sub-national governments, increased. As a result, when the Executive sought the approval of a policy

initiative in Congress, it had to bargain in most cases on an individual basis with legislators (Shugart, 1992).

The impact of the ANC and its new Constitution on the balance of power between the Executive and Congress in policy making was ambiguous. On the one hand, the political use of national funds allocations was virtually abolished and field offices of central agencies—another source of clientelism—were ordered dismantled. This greatly diminished pork barrel practices and made the legislation process more transparent and more focused on the national interest. It also helped reduce the clientelistic conditionalities of Congress for the approval of an Executive policy initiative. On the other, the new Constitution devolved to Congress two prerogatives that strengthened its negotiation power *vis a vis* the Executive. One was the restoration of the Congress' prerogative (even if limited by the requirement of having the Finance Ministry's approval) to present public expenditure initiatives. The other was the reduction of the type and number of policy reforms that could be sanctioned by Executive Decree, even if at the same time the Executive was left with the entire responsibility for their formulation.²⁰

Furthermore, the new Constitution mandated that some key policy initiatives be approved by Congress as Organic Laws, thus augmenting the need for negotiation and consensus building during the legislation process. Simultaneously, the new Constitution gave Congress strict deadlines for the approval of law initiatives on strategic issues. This was yet another mechanism to press actors to achieve satisfactory agreements for the approval of certain bills on both sides, since it limited the Congress' veto capacity, while at the same time forcing the Executive to search for a compromise on policy content, in order to obtain the necessary votes on time for the approval of a law.

While this new institutional arrangement was not entirely successful in eliminating the clientelistic *modus operandi* in Congress and its relation with the Executive, it did drastically change the negotiation arena of the political actors in both branches of power. It made the policy process more complex, particularly during its legislation stage, and limited the Executive's space for maneuver in formulating and passing new policies without a long process of consensus building over policy content with different political forces. This forced the Executive's change teams to use more open political strategies in order to interact and "market" their policy proposals to legislators, even to assist the members of Congress in charge of presenting the bills. Interestingly, the continued factionalist politics of the traditional parties helped the Gaviria government secure the needed number of votes for the approval of its policy initiatives, since it could compensate the loss of votes of members of its own party with a number of votes from the Conservative party, particularly from a new technocratic and pro-modernization faction, led by future president Pastrana, called New Democratic Force.

Also as a result of the new Constitution, society turned its attention to the policies being discussed in Congress, thus subjecting the process to a much higher degree of public scrutiny. The politicization of the policy debate was further increased by the weakening of the Gaviria government, who had lost society's original support in bringing about radical reform, and was facing the lowest levels of popularity due to a perceived mismanagement of the drug traffic and energy crisis. This gave new power to social actors such as unions, which found effective means to influence decision-making and veto policies counter to their interests. This was particularly the case during the approval of legislation regarding the social sector. A case in point is the attempt at decentralizing education, which ran counter the interests of the teacher's union (FECODE).²¹ FECODE called a two-month long strike

²⁰ A characteristic of the 1991 Constitution is that it left central government a relatively large room to prepare and present to Congress strategic bills, including those of decentralization, public services regime, social security, oil royalties, education regime, and budgetary process.

²¹ This involved devolving to municipalities control over the teachers' posts – contracts, salary level, benefits, job location, etc.

and made the government change its position. This stands in stark contrast with the low profile unions had assumed during the rather expedient approval of the labor reform. This reform, which affected in a significant way all formal workers, took place during Gaviria's first six months in power, while the country was preparing for the Constitutional Assembly.

In contrast to the first group of reforms geared at economic adjustment (also known as first generation reforms) presented by the Gaviria administration and approved before the Constitutional Assembly, the social sector reforms, or second generation reforms, had not reached their implementation stage when the administration came to an end. This reflects not only the complexity of the content of this group of policies, but also the fact that the process of formulation and legislation was much more lengthy and controversial than that of the first group of reform proposals. Since it cannot be argued that the first generation reforms were less controversial, one has to conclude that the determinant factor was the context in which both groups of reforms were legislated. The first generation reforms were formulated and legislated during Gaviria's first years in office, when he counted on a strong popular mandate for reforming the State and had enough time to implement and consolidate policy changes. The social reforms were legislated during the second period of the Gaviria's government during a particular time in which Congress enjoyed a recently acquired leverage due to the new Constitution. Also, as opposed to the first generation reforms, Gaviria's administration was coming to an end, and there was no time left for their implementation.

THE SAMPER ADMINISTRATION (1994-98)

In August 1994, Ernesto Samper, the official candidate of the Liberal Party, was elected President for the period, 1994 - 1998. Since the early beginnings of his administration, the Colombian political dynamic suffered a radical change that turned it back to something closer to politics during the times of the National Front (1974-1986), than to politics under the Barco and Gaviria administrations. The main cause was the close split in electoral preferences reflected in the fact that he arrived in power with slightly more than 1% more votes than his conservative opponent, Andrés Pastrana, in the second round after Pastrana had won in the first round. The other major cause was a political scandal related to the use of drug traffic money for the political campaign, from which the Samper government was never to recuperate.²²

President Samper had a profile that was more political than technocratic one. Besieged by the drug money scandal, he based his policy making in the construction and maintenance of large and heterogeneous coalitions of political support, with the marked presence of the traditional political leadership. As a result, his government's composition reflected the 50% -50% arrangement similar to the coalition governments of the National Front accord, and the fulfillment of political quotas prevailed over technocratic meritocracy. Furthermore, decision making on budget allocations and

²² After Samper was elected, but before he assumed office, allegations that the Liberal campaign had been financed with money from the Cali drug-cartel were made public. By the end of his first year in government, the Defence minister – his closest ally during the campaign – was imprisoned along with another dozen Liberal congressmen as a result of the investigations developed by the general prosecutor. In such a situation, President Samper decided to form a coalition government, in order to achieve a clear majority in Congress, since this was the only branch of power that could conduct an eventual political trial against him. This resulted in the most serious political crisis in Colombia since the early 20th Century, but President Samper managed to complete his term and the Congress declared him not guilty.

implementation of projects were going to have a clear bias towards political survival²³. He did, however, maintain the technocratic profile of the key ministries, by naming Perry and Ocampo, two respected economists, as heads of the Finance Ministry and the National Planning Department (DNP) respectively.

The Samper administration differed ideologically from the Barco and Gaviria administrations. In fact, during his term as Economic Minister under the Gaviria administration, Samper headed—along with then Agriculture minister, Ocampo—the most visible resistance to Gaviria’s policy agenda stemming from within the Executive. He and his faction opposed the radical liberalization measures promoted by Gaviria and his economic change team. Also in a great departure from the top-down policy making strategy of the two preceding administrations, he believed in a much slower pace for policy reform implementation and prioritized consensual decision making in his cabinet with a particular emphasis on interest group consultation, particularly in the case of organized labor.

Consequently, the economic team of the Samper administration did not resemble the small, isolated, and powerful group of technocrats that worked close to the President. Instead, although the Minister of Finance and the Planning Director still held the most influential positions, their margin of maneuver was severely limited by the participation of other cabinet ministers as well as many presidential advisors, who were given voice and veto power in cabinet meetings.

During the Samper administration, unions as well as provincial and local communities resorted to strikes as a common negotiation strategy to press the State in favor of their interests, in the case of organized labor, and more public resources, in the case of the latter. Reforms, and indeed policy making in general, required negotiation and consensus building not only among policy makers and the political class, but also with organized interest groups, particularly the unions of key sectors such as oil workers, teachers and health workers. The government’s response to this style of politics, as well as the weaker stand of the economic team severely limited the State’s capacity to control the national budget. Any of the cabinet ministers was able to sign government commitments for further budget allocations without the approval of the Finance Minister.

It was in this political context that the reforms formulated and legislated during the Gaviria administration were to be implemented. These included, among others, decentralization, education, social security, and health. Furthermore, President Samper’s visible opposition to some of these reform initiatives during the previous administration, not only was a clear precedent of his intention to modify them during their implementation, but also sent confusing signals about his administration’s support for them. This was going to have serious repercussions in both the pace and the final characteristics of the reforms, with health being no exception. Interestingly, while reforms such as decentralization and trade liberalization were drastically modified and in some cases halted—with some attempts at reversing laws already approved in Congress—the Samper government moved ahead with the social sector reforms. This rendered political dividends, since it emphasized an image of giving priority to the social sphere over the economy.

²³ A large number of appointments in the bureaucracy as well as in the higher levels of government were made according to political interests and commitments. In similar manner, public projects were developed in regions where loyal congressmen had their political bases. Government agencies were once more captured by local interests and political leaders. Pork barrel politics resumed in Congress, through pressing for larger quotas in budget allocations and with a more visible political use of social programs (Salazar, 1998).

CONCLUSIONS

This chapter has described the main characteristics of the political context in which the Colombian health reform initiated in the early nineties, was formulated, approved, and began to be implemented. For this purpose the main arenas of policy making have been described, such as the Executive, Congress, and the ANC as well as their policy-making strategies (both formal and informal). The decentralization of the country and the importance of its regions also affected this process of policy making. Those factors have had an impact on both the legislation and the implementation processes, particularly in sectors like health.

In Colombia, the Executive has important policy making powers. While some policy initiatives need to be approved by Congress, many others remain in the domain of the Executive alone. This situation, even when modified by the ANC, has played a key role in the State's ability to bring about policy change. This ability has been reinforced with the creation, started in the late 1980s, of pockets of efficiency within government agencies, particularly in the economic institutions such as the Central Bank, the Ministry of Finance, and the National Planning Department, that have counted on varying degrees of political support. Groups of technocrats stemming from these institutions, with the political backing of top decision-makers, have worked in the form of change teams, and as such, have played a key role in the State's capacity to formulate and pursue policy reforms, particularly in the economic sphere. During the early nineties as part of a major State reform that touched the economic and social spheres, change teams were also developed in social sectors such as health and pensions, and were empowered to develop and pursue policy reform.

Nevertheless, these reform proposals faced resistance at various stages of the policy process stemming from different policy nodes. The first one was the Executive itself, where opposing views and ideologies on economic reforms had confronted each other in the 1980s and early 1990s, and were to do so again on social reforms throughout the 1990s.

On the other hand, most reform initiatives have to be discussed and approved in Congress. This interaction between the Executive and Congress is a complex one, due to the characteristics of interest representation in Colombia and the configuration of the legislative chambers. For many congressmen, incentives to participate in policy process formulation are more related to the patronage resources they may tap into, than to having influence over the end result of policy decision making. The high levels of party fragmentation and factionalism reduced the veto power of the opposition, but, by the same token, severely hampered the Executive's efforts at consensus building and eventually securing the needed votes for the approval of a law initiative.

There are other groups that intervene in the process of policy making such as producer associations, unions, think tanks, the media, and interest groups affected by policy decisions. They have a varying level of influence depending on their own political resources; i.e., level of organization, economic resources, importance of their economic activity, among others, and the political circumstances in which the reform process is evolving. However, with very few exceptions, they all share serious impediments in their efforts to influence policy making due to lack of representation of their own membership, fragmentation, and poor institutional mechanisms for interest participation.

In the case of the health reform initiated in the early nineties, the political context around its policy process played a key role. A social mandate called for the drafting of a new Constitution and a profound reform of the State, political institutions, and the economic and social spheres. The Gaviria administration saw in this a window of opportunity to pursue, with the backing of Congress, first a series of economic reforms geared at economic liberalization, labor reform, and the reconsideration

of the State's role in the economy; and second, after the ANC, a package of social sector reforms, which included education, housing, social security, and health.

However, while the Gaviria government had enough time in power to implement its first package of reforms, it only managed to formulate and legislate its social sector reforms. The implementation of the latter was to happen in a radically different political context and under an administration with a different ideological stand. The policy-making strategies of the Samper administration also were a radical departure from those of the former one. It emphasized consensus building and believed in the need for a slower pace at policy change in order to adapt reform initiatives to the needs and possibilities of the country. The political management of these strategies was complicated by a political crisis that severely reduced the government's capacity for action and radically changed its policy priorities.

These circumstances gave enormous influence to Congress and different interest groups, such as unions and the economic groups, who thus were able to obtain important concessions such as salary increases, privileges, and modifications to policy content. While these political circumstances seriously hampered the State's capacity to pursue policy change, major policy changes were implemented in the case of the health sector reform, if at a much slower pace than first envisioned. Interestingly, the health reform was to become one of the most visible results of the Samper administration.

II. THE POLICY PROCESS

In December 1993, after one year of discussion, the Colombian Congress approved the Law on Social Security Reform (Law 100, 1993). This law contains two sections: pension reform and health services reform. The norm introduced critical changes in those sectors and was part of a larger State reform. This chapter focuses on the process of health reform by which the rules of the game were modified in order to achieve universal access to the health component of social security, and greater equity and efficiency in the health care system. The chapter is divided as follows: the background of the reform and a brief exposition of Law 100; the process of problem definition and policy formulation; the process of the reform's legislation; the process of reform implementation; and concluding remarks on key policy nodes and actors.

BACKGROUND

THE PROBLEM

During the early 1990s, when the health reform started to be discussed, there was a consensus about the need to reform the sector. Colombia, as many Latin American countries, had poor health conditions: the main problems included low coverage; high degree of segmentation in access to health care; high cost for the poorest; and considerable levels of inefficiency. Nevertheless, there was no imminent crisis that threatened the survival of the system as it was, at least in the short term.

In 1991, in spite of compulsory affiliation, only 20% of the population was covered by social security. Although the ISS apparently had the monopoly of social security, it covered only 16% of the people and by 1991 there were 1,040 agencies of social security in the country. Parallel systems were in operation: some governmental agencies had developed systems of health providers (coverage of 4%); the Cooperative Organizations offered some health services for formal sector workers and their families and private insurance covered the health of the wealthiest (4.5%). There were also experiments with cooperatives and mutual organizations. This spontaneous institutional development generated an overlapping of expenditure and affiliation, segregation and few incentives to save²⁴. The rest of the population relied on public facilities for their health care, which in fact reached just half of them, offering low quality services.²⁵

Finally, the Ministry of Health concentrated its efforts on financing and administering the public hospital system directly. There had been efforts to transform the public system by turning over health care centers to municipal governments, and primary and secondary health care institutions to departmental governments. Nevertheless this early attempt at reform faced resistance and was not fully implemented.

²⁴ Londoño, J. L. "Managed Competition in the Tropics?" Paper presented at the International Health Economics Association Inaugural Conference, Vancouver, May 1996.

²⁵ Jaramillo, I, "El futuro de la salud en Colombia. La puesta en marcha de la Ley 100." Fescol, FES, FRB, Fundación Corona, Santafé de Bogotá, 1997.

THE ORIGINS OF THE REFORM

The origins of the health reform can be found in the 1980s (Jaramillo, 1997). During this period, a reform for the public sector began to be discussed with two dominant trends: decentralization or privatization. Initially, major changes were developed towards decentralization, and they transformed the health system established since 1975. Those changes began to introduce certain ideas that were fully developed with the reform in 1993. For instance, Law 12, 1986 established a shared scheme for the IVA (Value Added Tax) between local and central governments. This innovation introduced decentralization mechanisms that are at the heart of the 1993 health reform.

Other examples of this process can be documented as well. President Barco (1986-1990), for example, promoted hospital autonomy, influenced by the English Health Reform.²⁶ This issue became one of the main features of the health reform approved in Law 100, 1993. Another precedent was set when President Barco appointed an economist as Health Minister for the first time in Colombian history. For Barco, the main problems with health were administrative and technical. This fact was consistent with the importance given by Barco to the technocracy, a tendency that President Gaviria continued during his government, particularly when he appointed Juan Luis Londoño as Minister of Health. During the late eighties even the idea of a subsidized regime with risk adjusted per capita payment was discussed, but it did not progress at the time. This turned out to be one of the key mechanisms of the health reform of the nineties.

During the eighties there were other decisions that set important precedents to the Law 100, 1993. Decentralization of health expenditure was set in motion; the National Hospital Fund was reformed and the Health Superintendency, now a major agent in the new system, was created. The National Foundation of Traffic Accident Insurance (FONSAT) was established. It has become an important source of resources for the health system, and it introduced a precedent for a tariff system, which is an element of the reform. Moreover, it is a type of demand subsidy. Finally, Law 10/1990 reorganized the National Health System and decentralized responsibilities, in addition to resources, which had been decentralized before. During the years leading up to the reform, there was also discussion about the feasibility of funding the social security system through pay-roll taxes, as well as demand for regulation as a result of the growing number of private pre-paid medical organizations.

Thus, it can be argued that during the nineteen-eighties many instruments were introduced that later became important in the reform of the early 1990s. However, the discussion of a radical reform as such was clearly accelerated in 1991. A National Assembly to amend the Constitution was called while President Gaviria was in office, which continued a process started under the Barco administration. Agreement on the new Constitution was reached six months later. This contributed to an important institutional change, and the social security reform was part of it. In addition, Gaviria's government had introduced reforms opening the economy and establishing labor, financial, and monetary reforms. In the health sector, the Ministry had been restructured as well as the National Fund for Hospitals, the Health Superintendency, and the ISS and social security institutions for public workers.

A point of particular relevance for the health reform was the Labor Reform. This was the last reform approved by Congress before the ANC called for a new Congress. The Executive's project that introducing measures to make this market more flexible was approved almost entirely, with the exception of the request by the Executive for special powers to reform social security, particularly the pension system, by decree.

²⁶ Barco had witnessed the reform as Colombia's Ambassador in London.

It is also important to mention a key complement to the health reform, Law 60, 1993. This law, discussed simultaneously with Law 100, was approved few months before the social security reform. Law 60, according to the Constitution principles, defined governmental functions and resources for the territorial authorities, particularly in the social sectors.

LAW 100, 1993

According to the new Constitution, the main characteristics of the social security system are universality, solidarity, and efficiency, and it should include a plurality of public and private actors in an environment of financial sustainability. Those principles already represented an agreement between two different forces: those giving priority to solidarity and those favoring efficiency. In addition to these two principles, Law 100/1993 introduced others like integrity of care, quality of services, decentralization of resources and responsibilities, and consensual political decision.

The new system intends to provide **universal health coverage** through a compulsory social security system. This system is constituted by two regimes, one of them contributory and the other one subsidized. The first one covers employees and independent workers who can afford to pay. The second one covers the poor, estimated to be about 30% of the population. Both regimes will have the same package of basic services provided through a compulsory health plan (POS) by the year 2001 (8 years after the reform). The new system includes **solidarity** mechanisms such as:

- the establishment of the UPC (Risk Adjusted per Capita Payment), which allows potentially equal resources for all beneficiaries independent of their capacity to pay or risk of sickness.
- in the case of the contributory regime, the premium to enroll in an EPS is made according to the payment capacity and not according to the risk probability.
- families under the contributory regime allow 1% of their payment to go to the subsidized regime, and this contribution should be matched by at least the same amount of resources from public sources.

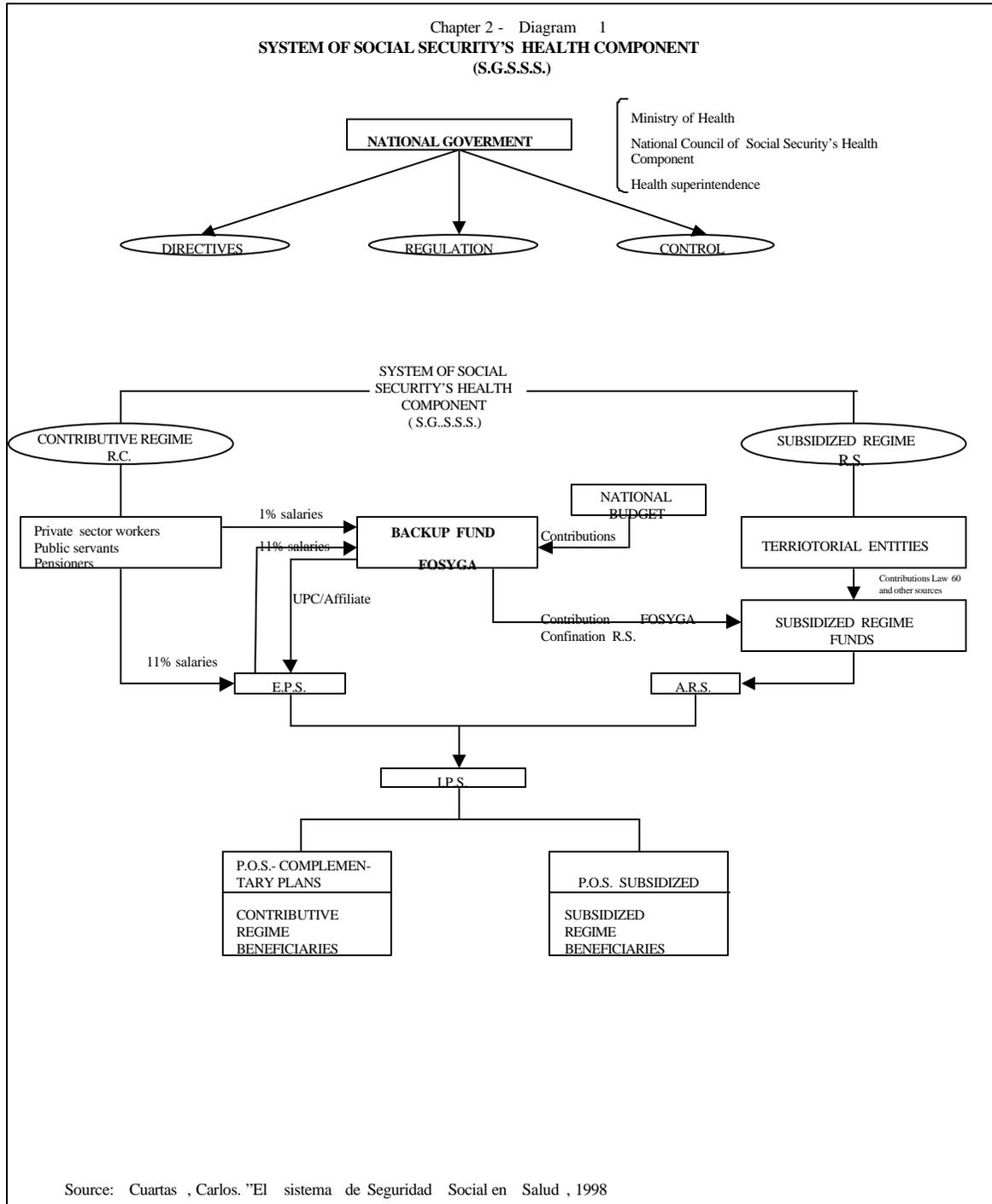
Finally, the new system encourages **efficiency**, through the promotion of prevention; the allocation of resources according to demand and not supply; and the inclusion of competition among the EPS.

2. *New Institutions*

With the passage of Law 100/1993, a National Council for Social Security in Health was created with regulatory powers over the system, leaving management and technical assistance to the Ministry. Provision of services was shifted from the Ministry to local agencies and independent providers, and a Superintendency was created to monitor and survey the system. The system separated financing and delivery by creating a National Health Fund, FOSYGA, which is independent from the social security organizations.

Finally, the Law distinguished entities that provide health services (such as hospitals) from those that finance or organize them: the IPS (Health Service Providers) supply services and the EPS (Organizations to Finance/Organize Health Services) purchase them. Every person has to enroll in an EPS, or in the case of the subsidized regime, also in an ESS (State Social Sector Enterprise). Competition was created for the integrated delivery of services, but not in financing, to minimize dispersion of services and segmentation of markets. Free choice was established. Families can join any EPS for a minimum period of one year and then they can change. This was to promote competition and guard against adverse selection (Londoño, 1992).

Figure 2. The Social Security System's Health Component



2. Funding

Every family contributes to the FOSYGA according to its ability to pay. The services in the contributory regime are financed by a contribution of 11% of its income. The Fund pays the EPS selected by each family according to its level of expected risk (UPC). One additional percentage point of the contribution goes to a solidarity account as a contribution to financing the subsidized system. The resources for the subsidized regime come from a combination of the national budget, territorial resources, and the 1% wage contribution from members in the contributory regime. Through this flow of resources, the reform attempted to establish solidarity and redistribution instruments.

PROBLEM DEFINITION AND POLICY FORMULATION

The health reform discussion gained momentum during the ANC and there was a great deal of debate from that moment until the approval of the Law. It continued during the drafting of the decrees to implement the Law and the implementation process itself. During this period, diverse groups intervened and there were several key moments when the proposal was modified. The main events in the reform process were the promulgation of the new Constitution, the Commission for Social Security created by the Constitution, the Congress, the secondary law formulation process, and the definition of the transition period at the beginning of implementation.

There were different positions, both within the State and in society in relation to what the reform should be. The tensions that were present and the final result are summarized by Londoño (1992) as follows: “from a political perspective, the spontaneous growth of multiple health systems serving different populations and groups generated interests and forces that prevented extreme reform options (...) such as turning the system to the State, the municipal government or the private sector. These pluralistic political forces could only be reconciled through a Law establishing a structured system of rules and equality of conditions for all participants in the new system.”

This section addresses the main debates and positions prior to the process of legislation. This was a definitive moment because this was when the two main positions around the reform—one in favor of a strong role for the State and the other in favor of a greater role for market forces and private participation—were discussed. It is at this stage, and as a result of the debate, that many of the key characteristics of the new system were defined, including the existence of a mixed system with elements of solidarity and equity as well as the principles of efficiency and competition. Even when the government was a key actor and had great influence, its initial proposal had to be radically modified during the debates.

A NEW CONSTITUTION

Between January and June of 1991 a new Constitution was debated; subsequently, it was approved on July 4th. The final document was the result of the work done by a group of people who were elected under new rules that ensured an unusual representation of all groups in society. Their composition was wider than that of the membership of Congress. Even when there were representatives from the traditional parties, there were also people from the academy, the regions, members of guerrilla groups who had agreed to a peace process, and people representing minorities such as the indigenous population and Christian groups. It is at this moment that the debate around a social security reform, which included the health component, started in a systematic and comprehensive way.

It was during the discussion of the new Constitution in 1991 that the idea of a health reform, as part of the social security reform, took momentum. The new Constitution, through Articles 48 and 49, defined social security as a compulsory public service under state control, following the principles of efficiency, universality, and solidarity. According to the Constitution of 1991, the service should be decentralized and could be provided by either public or private agencies. The Constitution finally established the creation of a Commission to elaborate a proposal, within six months after the promulgation of the Constitution, to establish the basis for social security reform.²⁷

This was the final agreement. However, during the debate of the Constitution, mainly within the Commission V in charge of economic, social, and ecological topics, there were two main positions. On the one hand, the government (with the exception of the ISS group, but with the support of some members of the ANC and the private sector) intended to introduce competition to increase efficiency. On the other hand, a second group worked to promote solidarity, universality, a non-segmented system, and wanted to preserve a strong role for the State. During this time the debate around the Chilean model was very important. The experience of the Chilean ISAPRES was evaluated, and it was seen as a highly inequitable model where competition had broken the solidarity mechanisms. Nevertheless, other principles of the Chilean model were seen as desirable, such as ending the monopoly and incorporating the private sector into the system. Since at the end there was no agreement, the Constitution established a consensual combination of both positions as social security principles: solidarity and universality, but with efficiency and the participation of the private sector in the provision as well.²⁸

THE NATIONAL DEVELOPMENT PLAN

While the ANC debates were still in progress, the Government was developing institutional reforms and defining the National Development Plan, the latter particularly through the DNP. This Plan was ready in August 1991, one month after the promulgation of the new Constitution. While the discussions at the ANC were open and many points of view were presented, the debates that took place about the basis of the National Development Plan were technocratic ones. Those discussions were between technicians from the DNP and other experts (many from the academy), but not with representatives from wider sectors of society. The aim was not to build consensus or to involve many groups in society. This approach was also present in dealing with social security and health. Therefore the health policy defined in the Gaviria administration development plan, even when trying to introduce the new principles defined by the Constitution, still represented the initial governmental position toward the reform, which still was to be modified during the process.

The National Development Plan of President Gaviria, “La Revolución Pacífica”, did not have a proposal for health reform as such.²⁹ Health policy was oriented mainly towards improving efficiency and strengthening local health services. The Plan did not mention a comprehensive social security reform. The Plan did state that the main points of the proposals for a reform should be left to the Commission on Social Security, as established by the ANC. However, it had the following recommendations for that discussion: to introduce family coverage (before the reform it only included

²⁷ Constitución Política de Colombia, 1991 (Article 57, transitory).

²⁸ Salazar, M. found the same procedure in relation with the approval of the decentralization proposals during the Constitution (PhD dissertation in progress).

²⁹ Prior to the Gaviria administration, the National Development Plan, by which every government organizes its investment projects, was made by technocrats at the National Planning Department and was approved by the President and his ministries. The Constitution of 1991 altered the process. Even when the Plan is still the responsibility of the National Planning Department, it must be discussed by an elected National Planning Council that represents civil society, and subsequently must be approved by Congress.

the affiliated individual), to eliminate duplication in the provision of services, to separate the pension and health components of social security, decentralization, purchasing of services from public or private institutions by the agents of the social security system, and the introduction of choice for consumers. In addition, as a pilot experience there was a general proposal to develop pre-paid health systems for the poor, with resources from government through vouchers and with co-payments by the users, establishing demand subsidies and targeting procedures.³⁰

THE SOCIAL SECURITY COMMISSION

When the ANC ended, its members realized that there was no agreement on the definition of social security and therefore in Transitory Decree 57, they established the creation of a commission. This Commission worked during the last four months of 1991 at the Ministry of Labor. According to the decree, this Commission was comprised of people coming from government, unions, productive associations (*grimes*), political and social movements, peasants, and informal workers. The topics of health, pensions and professional risks were discussed by the different sub-commissions. The health component discussion group was coordinated by Antonio Yepes, who had been a member of the ANC himself³¹ and had seven members: two representing the government, two representing the unions, one representative of small industries, one from the Liberal Party and one from the agriculture society.

According to some participants, those meetings were focused mainly on the definition of social security. They were dominated by the unions and the Government was not able to generate support for its proposals. In addition the Government was divided into two factions: the ISS with a pro-state intervention position and the DNP with a pro-market position that finally evolved into a moderate proposal. This was a key characteristic of the Colombian health reform. One of the most important policy nodes was inside the Executive, not just between the Executive and outside forces in society.

According to some people as a result of the general terms of the debate, there was a lack of consensus and lack of clarity around the reform. According to others, the government strategy was to let the Commission work during the established period, knowing that it was going to languish, so that at the end there was not final agreement on the main issues of the reform. However, there was some consensus reached with regard to topics like introducing competition and having compulsory and universal social security in health (Interviews, July 9 and 27/1998).

Nevertheless, during that stage several four main proposals were presented. The DNP proposal was closer to President Gaviria's ideas and the characteristics of the state reform promoted under his government. This included elements like introducing competition and establishing a new role for the private sector in order to promote efficiency. According to some who opposed it, this proposal wanted to introduce the Chilean model of social security in Colombia; i.e., privatizing the system and giving solidarity a secondary status. On the other extreme, the ISS wanted to maintain the social security monopoly for the state, introducing competition only during the provision stage. The Ministry of Health, which was under the charge of the M-19, wanted to make a reform maintaining solidarity and introducing some competition. However, this institution was not able to exercise significant leadership in the process at this moment. Finally, ASMEDAS, representing the unions, wanted to maintain the monopoly for the ISS in every aspect: affiliation and provision of services.

³⁰ Departamento Nacional de Planeación. "La Revolución Pacífica." Bogotá, Agosto 1991.

³¹ In 1994, under President Samper, he became director of the ISS. On the other hand, during the debate of the Constitution, the ISS group found in him a good ally.

The main points of discussion within the Commission were over maintaining the monopoly or introducing competition; defining solidarity mechanisms; deciding the role of public hospitals and the characteristics of the subsidized regime; and establishing a role for the private sector and its proposal of complementary packages or different plans for different payment capacities and free choice by the users. Those topics were at the heart of the discussion during the whole process of formulation and definition of the reform. Since then, the debate was polarized around these issues. Even more, disagreements on those points have continued during the implementation process, affecting the final outcome of the reform. There are two extreme positions: on the one hand there is a group promoting solidarity, integrality, universalization, and a unified system managed by the ISS. On the other, there is a group promoting free choice, competition in affiliation and in provision of services, and transparency between the origin of the resources and the benefits provided.

After the Commission ended its sessions at the beginning of 1992, the Government reorganized its strategy for the social security reform. In May 1992, the President changed part of his cabinet and Cecilia López left her position in the ISS, an institution that had opposed the type of the reform wanted by the technocratic team. In her place, Fanny Santamaría was appointed. Santamaría came from a senior position at the Ministry of Finance, where she was in charge of the National Treasury. Luis Fernando Ramírez was appointed as Labor Minister. He was a conservative young man whose work had been mainly in the private sector and was formerly deputy minister at the Ministry of Finance.

The President wanted unity inside the Government around the reform. He and his close assistants thought that the team in charge of it should come from his economic group and have the support of the private sector. This is also explained by the fact that at this point President Gaviria had decided to abandon the health reform and to focus his efforts on the pension reform, which was seen as a component of the economic reforms made by his government and a strategy to boost internal savings. The pension reform proposal was the component that was left for further development during the 1991 Labor Reform. In September 1992, the government presented to the Congress a project with the social security reform for pensions: Proyecto de Ley 155, September 1992.

THE POSITIONS AROUND THE REFORM

After the commission ended its work, the debate continued during 1992 and became even more heated. University forums, several meetings among specialists, and international seminars also took place. The government, with its different positions was present in most of them; moreover, the government promoted some of them. This debate went on not only in Bogotá but also in the regions. Several groups contributed to the discussion: the Government, which did not have a unified position until May 1992; unions; “think thanks” such as Fedesarrollo, Fescol, and Consenso (the team that left the ISS with Cecilia López’ resignation); NGOs such as Fundación Corona, Instituto Fes de Liderazgo, and Metrosalud; and universities. It was a process of learning and reflection for many of them, and during this period the proposals were gradually modified, concretized, and enriched.³²

At this stage the process was very participatory, and there was no clear leadership by any one group. The main tensions were represented by those who advocated solidarity and a predominant role for the state (ISS, Fescol, unions), and those who advocated competition, efficiency, and a stronger role for the private sector (DNP and Ministry of Finance with the support of the private sector).

³² There were complete proposals from ISS (1992), Minsalud (1991 and 1992), University of Antioquia (1991), Olof Palme Corporation (1991), and Fedesarrollo (1991).

Within the government there were three main proposals.³³ At one extreme there was a proposal based on a Unique National Fund, which would have the insurance monopoly, and would be founded with all the system's resources to ensure solidarity and equilibrium. Nevertheless, participation from private as well as public sectors in service provision was accepted and it included the establishment of a group of agencies organizing health services and serving as intermediaries between hospitals, beneficiaries and the Fund. They wanted a compulsory social security system that could provide integral care, and accepted demand subsidies for those who could not pay. The insurance payment would be done according to personal income and the services would be the same as those of the ISS, but with universal coverage. They accepted decentralization though through an incremental process. This proposal was identified mainly with the ISS-Consenso group³⁴ but had other supporters, such as the unions and members of left parties, as well as a wing from the Liberal party, particularly the "Samperistas."

The National Planning Department was at the other extreme, proposing a segmented system according to purchasing power. Nevertheless, after a period of transition, they argued, the system should be unified. They emphasized efficiency through competition; demand instead of supply subsidy; regulation for the private sector; payment to providers according to tariffs; decentralization; and a minimum package of services.

The Ministry of Health had an intermediate position. It proposed a scheme based on a general director as head of the system, a solidarity fund, insurance agencies, providers, and a strong emphasis on decentralization. They believed in solidarity and universality, but introduced some efficiency elements. They also agreed with a universal and compulsory insurance system; an integral package of services that could vary according to the region; a system with fiscal and para-fiscal solidarity, with free choice between insurance companies and service providers, and with independence in funding and management. To sum up, the DNP emphasized efficiency, while the ISS emphasized solidarity without competition. The Ministry of Health had a more conciliatory position.

In summary, the following were the key points of discussion:³⁵

- Formulation of one or more systems and their level of integration:

Integration of the two populations in one system with resources from both groups, in the case of the ISS-Consenso proposal, versus two different systems (contributory and subsidized) in the DNP proposal.

- Monopoly or competition in insurance, affiliation, and administration of the system:

The ISS favored a State monopoly because it prevented adverse selection and a segmented system, and it was the status quo. The DNP proposed competition because there was freedom of choice and economic efficiency. There were also some proposals in the middle, like the one from the Ministry of Health.

³³ Molina, Calos Gerardo y Trujillo, Juan Pablo. "La Reforma del Sistema de Seguros de Salud: una comparación de tres propuestas." Estudio elaborado para el Programa para el Mejoramiento de la Gestión Hospitalaria. Corona, FES, FRB, Abril 1992.

³⁴ The ISS-Consenso group is understood here as the one that under the leadership of Cecilia López defended the role of the public sector in the reform and emphasized equity and solidarity. This group left government in May 1992 to work in a research institute they created called Consenso.

³⁵ Ministerio de Salud, "La Reforma de Seguridad Social en Salud," Tomos I, II, III, Ministerio de Salud, Santafé de Bogotá, 1994.

■ **Public or Private System of Social Security:**

The ISS promoted a public system because it favored solidarity, homogeneity and prevented adverse selection. The DNP promoted a private system because it was flexible, efficient, with less corruption and more autonomy.

■ **Unified or different POS, premiums, and tariffs:**

For the ISS they should be unified, comprehensive, and, in the short term, independent from budgetary and institutional problems; DNP wanted to make them partial or progressive according to the availability of resources.

■ **Autonomy of the EPS in relation to insurance agencies and IPS:**

One position argued in favor of integration and it did so in the name of administrative efficiency. Others argued in favor of independence and they did so in favor of greater control, choice, and accountability.

■ **Amount of public resources for the system:**

Over this point there was no agreement until the Law 60 of 1993 was approved (June 1993), as well as when new resources from oil exploration and newly-discovered fields were made available for the social security system.

Nevertheless the proposals agreed on many issues such as family coverage, a contribution between 8% and 12% of the family income, compulsory insurance, freedom of choice between health providers, administrative autonomy for the providers, and a clear division between insurance and provision. One important point in common was the idea of separating the pension and health component of social security. Other points on which there were agreements included: achieving universal coverage, even when there was discussion in relation with the timing of it, providing a health plan in the case of the contributory regime, and the existence of the subsidized regime.

THE HATOGRANDE PROPOSAL

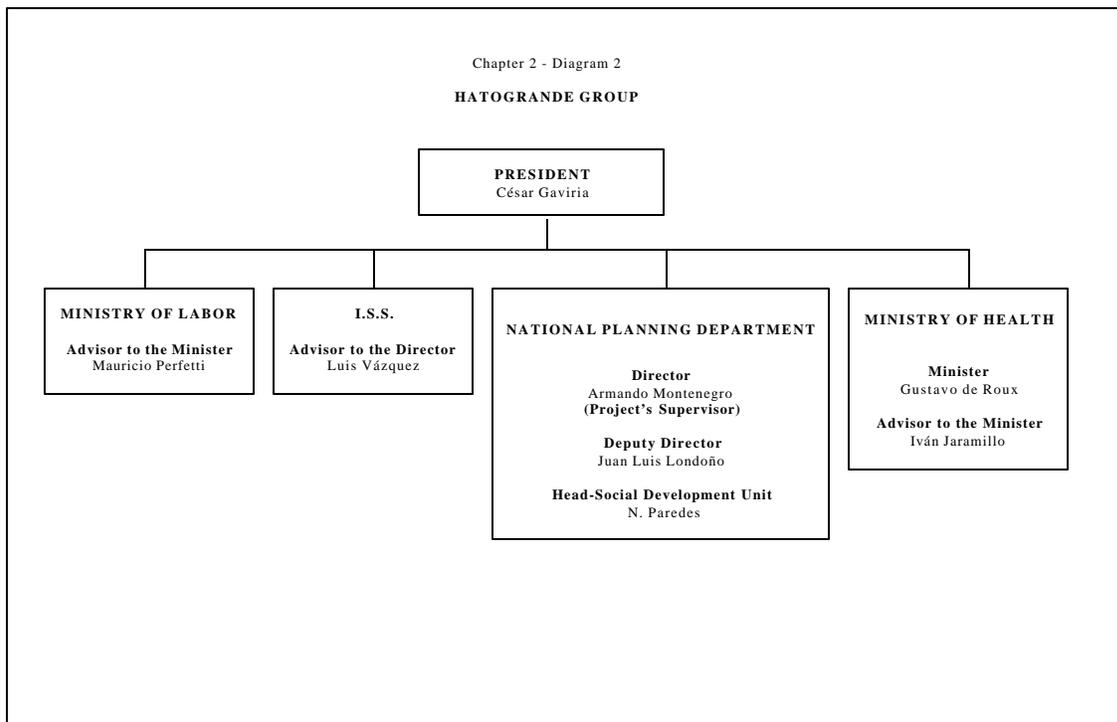
The initial bill 155 of 1992, presented to the Congress by the Conservative, Luis Fernando Ramírez, the Minister of Labor, in September 1992, did not include a health component and involved only a partial reform in pensions. It was not even called the social security reform, but the Law for the Creation of Pensions Savings (*Ley para la Creación de Ahorro Pensional*).³⁶ There had been many disagreements and much discussion in relation to the social security reform in health and President Gaviria himself felt that there were not enough economic, institutional, and political resources for the reform. He and his team chose to go ahead with the pension reform only, which was just one component of the social security reform. In addition they felt that the key points they wanted to put forward for the health sector did not have enough support.

Although Congress debated this proposal, by December 1992 when the sessions were over, its members had not reached a consensus. The bill encountered opposition on two fronts. On the one hand, there were those legislators who were influenced by the unions who feared that the reform would cut their benefits because the proposal included additional requirements to be in the system and offered fewer benefits. On the other hand, there were those who did not disagree with the

³⁶ At this time the “Cesantías” Administration Agencies were already working and it was an important antecedent. The Cesantías are another social security benefit for workers, which consist of one additional month of salary for each year worked that have to be paid by the employer. With the Labor Reform in 1990, specialized agencies were created to administer these resources that were previously managed by the employer.

proposal, but wanted to include health. This last position was defended by senators like Jaime Arias, a Conservative member of Congress who was a doctor and had been interested in health matters for a long time. He also seems to have a political base in that sector. Therefore, it was the Congress that at this point, in a meeting with President Gaviria, suggested the inclusion of the health reform as part of a broader Social Security Reform. This was a definitive reason to include health in the reform, and was reinforced by the pressure from other groups including CONSENSO. For some people, the principle of an integral social security system was not the only objective, it was also a strategy to delay the pension reform.

As a result of Congress' demand to include health as part of the reform, President Gaviria ordered



the creation of a high-level technical team to develop the proposal. It is important to point out that once the Executive decided to accept Congress' condition of including health, they also developed a strategy to regain control over that proposal. The team that developed the project was coordinated by the DNP. The individuals involved were Nelcy Paredes, Health Division Director for ten years and later Social Development Unit Director at the DNP; Ivan Jaramillo, advisor to the Ministry of Health; Mauricio Perfetti, advisor to the Ministry of Labor; and Luis Eliseo Vazquez from the ISS.³⁷

This technical team worked on a proposal that came to be known as the Hatogrande Proposal. The team was influenced by the ideas and proposals that had been developed around the pension and the economic reforms and their proposal was moderate in relation to the initial governmental project. It tried to introduce some elements of the different positions put forward during the previous debates. Their project included a system based on competition between providers, compulsory affiliation, and universal access. They also proposed mechanisms such as risk distribution and cross subsidies. This

³⁷ At this time Cecilia López was no longer the institute director, a position now filled by Fanny Santamaría.

proposal also defined two regimes, one of them contributory and the other one subsidized.³⁸ Once the proposal was prepared they presented the project to Montenegro and Londoño (DNP director and deputy director) who accepted it. On the other hand, Gustavo de Roux, by then the third Minister of Health during the Gaviria administration, was also familiar with the proposal and accepted it though he was not really committed to it. He thought that besides being too complex for the institutional capacity of the country, it was a partial reform that would only affect the health services provided by the Ministry of Health, but would not transform the ISS.

The “Hatogrande” proposal was presented to the President on November 16, 1992, but Gaviria did not support it. He found the project too complex and he thought it could jeopardize the pension reform. He was only interested in a negotiation strategy to have the pension reform approved. In this sense he was not interested in a comprehensive health reform project. Therefore, he decided it should be withdrawn. Instead, he proposed to include in the Social Security Reform a program for Health Solidarity Enterprises (Empresas Solidarias de Salud), an experience based on community participation and favored by the M-19 in the Ministry, that Gaviria had seen in South-east Asia. He also proposed to allocate an important amount of resources for this project.

At this point, the M-19 decided to leave the Government for reasons that are not clear. On the one hand the relationship of this political group with the government had deteriorated; on the other hand they did not agree with the treatment given to the health sector and the proposals that had been made for the reform.

Two weeks after that meeting, on November 30, 1992, Londoño, a Liberal economist, was appointed new Health Minister by the President. Londoño had served as DNP deputy director and played a key role in the economic reforms, developing ideas for the social sectors with the government’s technocratic paradigm. By this time Gaviria had already changed the Ministry of Labor and the Director of the ISS, and there was finally unity within the Government around the reform. From this time on, Londoño played a crucial role in the reform process, and became its clear leader.

On December 10, Londoño presented to the Congress the health project suggested by President Gaviria at the Hatogrande meeting. Londoño presented the project to the Congress in a very technical manner and it seems that very few people understood it properly. Nevertheless, the Congress saw that the Government again did not support a comprehensive health reform initiative, and they did not accept it. Congress was to insist on health reform as part of the social security reform.

By this time, the technocrats involved in the health reform on behalf of the National Planning Department were no longer there, and the influence of that agency in the reform decreased. In December 15 Nelcy Paredes, the Director of the Health Division and then Social Development Unit director at the National Planning Department, came to work with Londoño in the Health Ministry. Londoño had begun to put together a close working group around the health reform, as well as forming vertical and horizontal networks that became very important in the transition of the proposals through Congress and in the period of drafting the decrees needed to put the Law 100 into effect.

In December 1992 there was another event that also affected the reform: the Executive decrees for state reform were approved, and they included the transformation of the ISS, the Ministry of Health, the Health Superintendency, and the public sector workers’ social security institutions.³⁹ With the promulgation of those Executive decrees, the government tried to put forward some of its key

³⁸ Influenced by the Ecuadorian system, they proposed that after a period of time both systems should become one. Interview, July 27 1998.

³⁹ Decree 2148, 1998 reformed the ISS; decree 2164 the Ministry of Health; decree 3174 the Health Superintendency and the other social security institutions.

elements for the health reform, through a mechanism that did not required as much consultation as one that would have to be done in Congress.

LEGISLATION⁴⁰

A new stage of the health reform was the debate, discussion and approval by the Colombian Congress. This process took one year and, as before, it was surrounded by controversy.

The initial health reform bill presented by Londoño in December was limited. The reason was that the Executive was responding to the Senate's demands, but with a health program that would not affect the pension reform. Nevertheless, the Congress asked again for a more comprehensive reform. Londoño began to work based on the Hatogrande proposal, which by this time had been discussed with the ISS, Cooperative Organizations, pre-paid medicine agencies, local health authorities, and technical experts. Some degree of consensus had been achieved.

At the beginning of 1993 President Gaviria asked Congress to speed up the process of the reform, starting the debate not in April (as usual) but in early 1993. The Congress did not accept the proposal. However, during this month the Ministry of Health held some consultations about the project and in February of 1993 the presenters of the reform in Congress traveled to Chile to study their social security system—a trip underwritten by the Corona Foundation. It was at precisely this moment when the proposal was introduced to make the affiliation to either the ISS or other EPS voluntary, not compulsory (Interview, August 23, 1998).

The people working on the proposal were the same ones involved in the Hatogrande group with the exception at the beginning of Jaramillo, due to the departure of the M-19 from government.⁴¹ Within this group Paredes and Perfetti were still key actors—the former in health topics, the latter in pensions. At the same time horizontal networks were established with congressmen under the leadership of Alvaro Uribe Vélez⁴² and with his assistant, Eduardo Alvarado.⁴³ Alvaro Uribe was in favor of the ISS decentralization and the introduction of competition. Another member of Congress, Jaime Arias, was also consulted. He had developed proposals for a health reform based on the American reform. Other groups involved in the discussion were the Cooperative Organizations (Danilo Vega, president of Confecajas) and ACEMI (Paid Medical Association), who wanted to be part of a process that would affect them. The group also worked with the FES Macropolitics Group, whose main leader was Francisco José Yepes, and they benefited from the work of institutions such as the Paraninfo Group. The former organized a seminar in early 1993 around the different health proposals, and was relatively successful in promoting some degree of consensus.

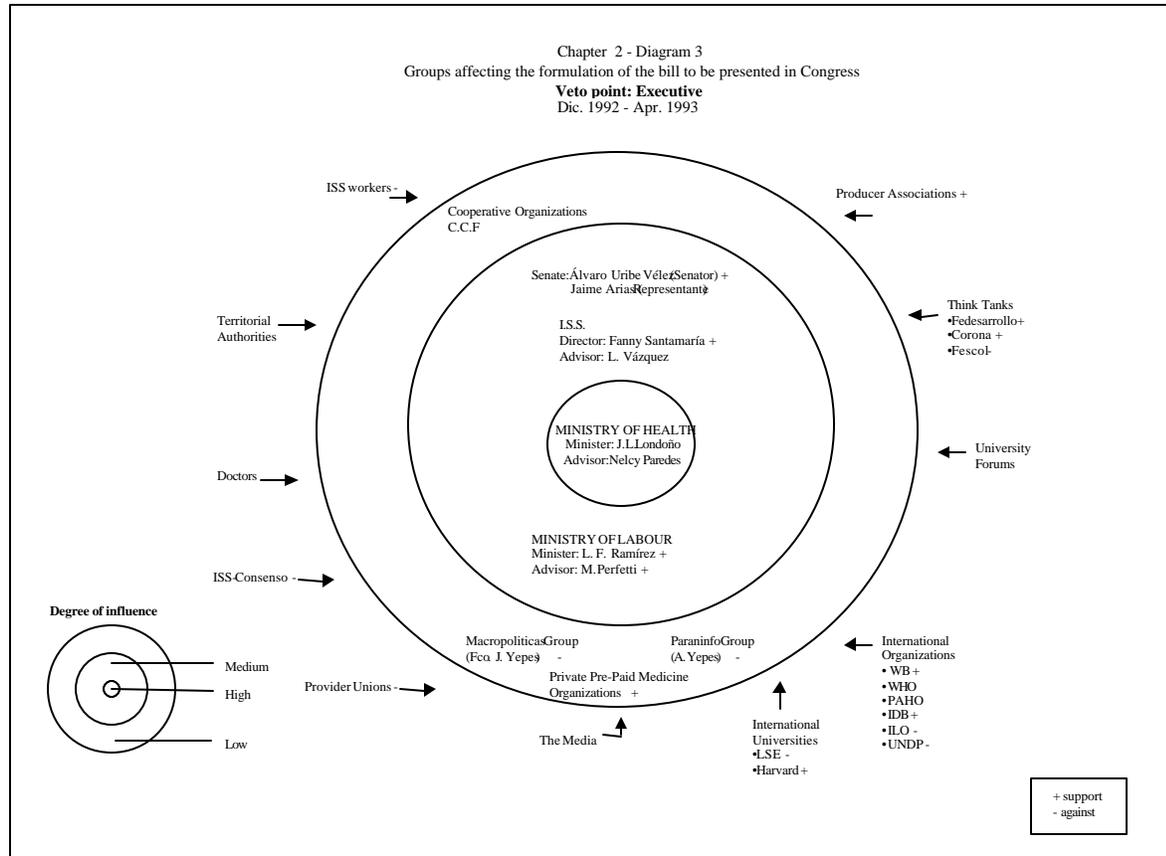
⁴⁰ The main source of information for this section, besides interviews, was: Ministerio de Salud. "Recuento del Diseño y Trámite de la Reforma." Bogotá, 1994.

⁴¹ Later, Jaramillo became advisor to Londoño. He also had some influence over the M19 members of Congress.

⁴² A Liberal from the Samper faction, but ideologically inclined towards the Gaviria administration. Other key legislators were: Jaime Arias, Conservative; Maria Cristina Ocampo, a Liberal from the Samper faction that stemmed from the Galan faction and at odds with the Gaviria government; Maristela Sanin, Conservative and sister of Noemi Sanin, future presidential candidate; and Jaime Corsi, independent and representative of the organized Christian groups that emerged as a result of the ANC.

⁴³ Alvarado had been Health Secretary in Antioquia and was Alvaro Uribe's advisor. He came from the Metrosalud group, where Yepes was working, and after the reform he became deputy Health Minister.

Based on the discussions held during February and March 1993, the group, under the leadership of Londoño assisted by Paredes, the Hatogrande proposal was modified. When the Congress started sessions in April 1993, the Executive, through Alvaro Uribe Vélez and María del Socorro Bustamante, presented an amendment to the initial bill. It finally incorporated an integral and comprehensive proposal for social security reform in both sectors: pensions and health. This proposal already included the combination of the two extreme positions and defined the contributory and the subsidized regimes; the National Health Board (CNSSS); the EPS; the IPS and the Solidarity Fund. It had solidarity principles and mechanisms both within the contributory regime and between the two regimes; and it introduced universality and efficiency through competition.



During the discussions of the Law in Congress, there were two main factions. One group in favor of the governmental proposal was comprised of the producers associations, some sectors of the traditional parties (Liberal and Conservative), private health providers, cooperative organizations, and international organizations. The group opposed to the project included the unions and the left political movements. There were also actors that had little influence over the reform like users and civic groups. This was probably due in part to a lack of trust in the process of policy making as well as the fact that there were no mechanisms for participation. Finally, doctors, even when consulted through their organization's directors (who were in favor of principles such as solidarity, equity, and universality), later felt they had not been sufficiently consulted during the process of reform (Paredes and Plazas, 1998).

During the debate of the reform in Congress, the main topics of discussion were:

- A debate between those for and against a segmented system. The government initially defended the first position, but they eventually had to negotiate. To solve this problem, they defined a unique Benefits Package for both regimes, with a UPC which prevented adverse selection.
- Funding was always a source of debate. An agreement was reached on two aspects: first, 12% of the salary or income of those who could afford it would finance the contributory regime, and second, resources coming from a percentage of the contributory regime, national budget and local resources would fund the subsidized regime. Nevertheless, even inside government there were disagreements, based on fiscal, economic, and political grounds. The economic team was afraid of both the fiscal burden the health reform could place on public finances and of increasing the percentage that employers and employees would have to pay from their salary at the same time both in pensions and in health. This was a decision that could also have adverse effects on the pension reform. Eventually, that contribution rose from 12% to 26% since 1995.⁴⁴
- The character and period of a transitional regime to ensure health care provision to the very poor through subsidies directed towards demand.
- The Benefits Package content was highly debated as well as the existence of complementary packages and the definition of pre-existing conditions. This point was largely discussed by ACEMI.

AGREEMENT IN THE COMMISSIONS

When the health reform went to Congress, it was initially debated by specialized commissions in the Senate and House of Representatives, in this case Commission VII, in charge of Social Affairs. The members of this Commission represented different forces and within it governmental and traditional actors from the Liberal and Conservative parties were not dominant. There were representatives from leftist parties such as the UP and M-19 and civic groups who had entered the political arena with the new Constitution, such as Christian movements.

At this stage the Law was debated with intensity, and modifications were introduced. The proposal was seen as a privatization attempt and a bid to abolish the ISS. On the other hand, some people wanted to preserve the ISS monopoly or to defend the social security benefits of public sector workers .

Those commissions generated a protracted and highly public debate around the reform, in which many representatives from the society were consulted. The main actors intervening in the discussion in Congress were representatives of the Ministry of Health and other federal government officials; territorial health authorities; and private health institutions. The latter included paid medicine organizations, health providers, the pharmaceutical industry, ASCOFAME, the Colombian Medical Federation, Colombian Hospital Association, National Medicine Academy, insurance sector, productive, industrial and financial associations (Consejo Gremial, Andi, Asobancaria), workers organizations and unions (Asmedas, Anea, SintraISS), Cooperative Organizations (Cajas de Compensación), NGO's and foundations (Corona, Fundación FES de Liderazo), think tanks (Fescol, Consenso, Fedesarrollo and Metrosalud), and independent people who were opinion leaders important in creating public opinion. For some observers and participants this process of debate was a democratic one, for others it was a strategy of Congress to delay the process. Finally, some saw this process as only a formal

⁴⁴ Two-thirds of that contribution has to be paid by the employer who also has to pay 4% to the Cooperative Organizations, 3% for the ICBF, and 2% for the SENA.

process of participation to legitimate the final outcome without really considering the contributions made during that process.

In spite of the consultation efforts, during the first months of 1993 the reform did not progress. By May not one single article had been approved. In addition, this was a period of union movements and protests against the decentralization reform being discussed at Congress (Law 60, 1993), particularly by FECODE and the USO, the teacher's and petroleum worker's organizations, respectively. At the end, those two sectors, as well as the armed forces were not included in the social security reform. At this moment of crisis, the intervention of President Gaviria was important. He promoted the signing of an agreement with the main leaders of the traditional parties, to support the reform. As a result, the study of the proposals was speeded up. However the debates continued until December and the different positions around the reform persisted.

At this stage the debate was open: many positions were put forward and many groups were heard during the discussions. Some participants in the process pointed out, however, that this process of general debate was a formality and that the real decisions took place outside those spaces and were made by a small group of actors within the Executive with some participation of Congress (Interviews, August 24, 1998, November 5th and 6th, 1998). Nevertheless, it introduced an important dynamic.

The main discussions were centered around the content of the Benefits Package, and the subsidized regime coverage and funding. The government, some members of Congress, and actors coming from the private sector, argued that the Benefits Package should be flexible and its content adjusted and if necessary reduced, according to the available resources. However, the decision moved towards the inclusion of every level of attention and every risk, as provided by the ISS according to the Decree-Law 1650, 1977. At the end a unique Benefits Package and a progressive coverage for the subsidized regime were approved.

With respect to the content of the POS, there were two points of view: one supporting an integral POS, and the other insisting that the content should focus only on prevention, promotion, birth attendance and basic services in order to reduce costs and be cost effective. The first position was defended by doctors through ASMEDAS and the Medical Federation, the unions, and Consenso. The second was advanced by the Ministry of Health, greatly influenced by the World Bank⁴⁵, as well as actors from the private sector such as the paid medicine and insurance companies. In the end, the principle of integral care was accepted, but a n initial period without access to certain services was included as well as the introduction of differential "co-payments" according to affiliation period and socio-economic level.

In relation to the discussions on funding, the promulgation of Law 60,1993, as well as the introduction of new revenues from petroleum exploration, clarified the flow of new resources for the reform and consequently facilitated the definition of the Benefits Package content and the transition period.⁴⁶

Another extended discussion took place around the composition of the CNSSS (National Health Board), given that all of the actors involved in and affected by the reform were to be represented on the Board. There were at least ten different proposals discussed by a sub-commission. They tried to establish a compromise among the proposals, selecting the members that were included in most of the

⁴⁵ Musgrave came as an advisor for the reform.

⁴⁶ Londoño took the leadership of the Law 60 project and, according to senior health officials, the final version of the Law that was presented to the Congress by Victor Renán Barco was written at the Health Ministry by Londoño's team.

Proposals.⁴⁷ Eventually a ten-member board was approved. During plenary sessions a new member was added, a representative of the municipalities.⁴⁸

According to Londoño, “The degree of participation of business and union organizations at the beginning of the reform was relatively low and most of their representatives accepted a seat on the National Health Board. This prevented large scale corporate problems.”⁴⁹ For Londoño as well as for other analysts this was a key point in the negotiations that helped to solve many disagreements. Different groups wanted to be involved in that board to maintain a degree of control over the reform. For the team in charge of the reform at the Ministry of Health, this situation did not represent a risk. In fact, they tried to reduce the power of the CNSSS to a formal role with little impact. Since then, the Board has gained space, but the Minister of Health is still the most powerful member.

The role of the ISS and its functions were also discussed during those sessions, particularly the issue of whether the ISS should be decentralized or even dismantled.⁵⁰ Nevertheless, the ISS did have its defenders—some members of Congress, including some Liberals; parties from the left and civil movements; unions; and the group from the ISS-Consenso. They supported the public role of the ISS as part of a broader position about the reform, in which the role of the State was the most important point. This point of view was partially reinforced by Samper⁵¹ in his run for the presidency, because he had the support of the unions.

During the discussion in the legislative commissions, some members of Congress with support from the unions, among other groups, wanted to reverse Decree 2148/1992.⁵² By means of this decree, the Executive had intended to reform the ISS as part of a broader institutional reform that did not have much consultation. However, there was no agreement on this issue and in the end the discussion was left for plenary sessions.

At the end, the ISS was not dismantled and it was left in a relatively strong position. However, its role was affected by losing its monopoly and the compulsory affiliation from private sector workers and having to compete with new institutions. On the other hand its services were extended to public employees if they chose to affiliate with the ISS. The institution’s hospital network could now be contracted by the new EPS or ESS.⁵³

A long debate took place in relation to demand subsidies. Those in favor (as the Ministry of Health), argued the advantages of free choice for users, and the need to redefine the public functions. Those opposed, intended to preserve the public status quo and saw the transition from supply to demand as very difficult. Eventually such subsidies were approved. At this particular moment, the

⁴⁷ Interview, July 1998.

⁴⁸ The DNP was not included.

⁴⁹ Londoño, *Ibid.*

⁵⁰ For Rudolph Hommes (Minister of Finance) and Fernando Botero, senator and president of the Commission this should be the case.

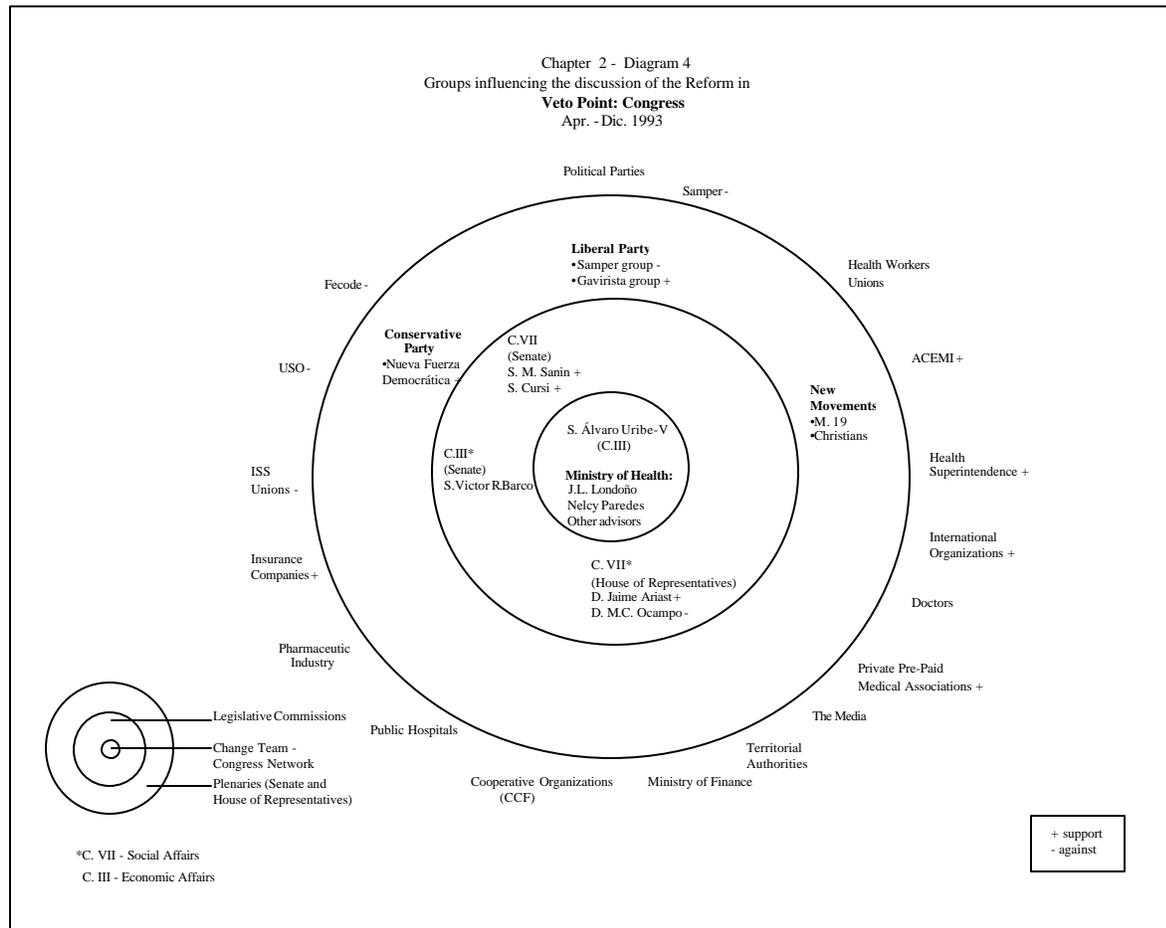
⁵¹ He was the liberal candidate for the presidency. In 1994 he became the new president.

⁵² This decree aimed at the State’s modernization giving the Executive extraordinary powers for this purpose. With this decree, the State reformed several ministries and government agencies and the government’s decentralization process was furthered. In the case of ISS, this decree was intended to decentralize most of its functions—it is one of the only government agencies that has not yet been decentralized—and to concentrate its activities in policy formulation and follow-up, rather than in policy implementation.

⁵³ Cuartas, Carlos. *El Sistema de Seguridad Social en Salud y el ISS*. DNP, Bogotá, September 1998.

reports on health published by the World Bank and the UNDP, were sources consulted for information and comparison with other experiences.⁵⁴

Finally, another point of tension was the definition of social security as an essential public service: some worker's organizations did not want this because it limited the right to strike. But in the end it was approved.



NEGOTIATIONS IN CONGRESS – PLENARY SESSIONS

After the reform was approved by the commissions in May 1993, it was discussed in plenary sessions in the Congress. The main modifications to the initial bill were done at this stage: the whole articles were debated again. The fact that the bill was deeply changed here, reflects again the amount of discussions generated by the proposal and the large scope of negotiations that were required to have the law approved.

The full Senate discussed the Law between August and November 1993. The main changes at this stage were in relation to the POS, particularly the convergence between the contributory and the

⁵⁴ World Bank Development Report: Investing in Health, 1993.

subsidized regime. Prior to the plenary sessions this point had not been particularly emphasized. The unions played an important role with respect to this particular issue. The Benefits Package of the subsidized regime was defined in relation to the UPC of the contributory regime. Even if at the beginning the contents would be different, according to the resources, the final agreement was that the Benefits Package would be unified by the year 2001. It was also established that the Benefits Package could be redefined and updated according to the demographic structure, the epidemiological profile, and the technology. The benefits were defined as different for affiliates and enrollees⁵⁵ and in function of resources. Cost-benefit analysis was introduced and priority was given to the first level of care that, in case of the subsidized regime, would gradually increase to cover the other levels of care, bearing in mind their impact on DALY's.

Another modification introduced during the Senate's debate was that the EPS themselves, were required to include insurance for high cost treatments they would have to cover. This helped to resolve, in part, the disagreement around the exclusion of pre-existing conditions from the system. This point was put forward during the whole debate by the paid medicine companies who proposed to define exclusions when critical conditions were detected before affiliation. This was not accepted. Nevertheless, a minimum waiting period before using certain services was agreed upon. Another point that the pre-paid medicine institutions lost, was the option to offer different benefit packages with different content, including exclusions and no pharmaceutical coverage. Even though they had support from some senators, in the end a single, unique Benefits Package was approved.

The Unions wanted to define every health worker from the public sector as an "official" employee, not a "public" employees as established in Law 10, 1990. Such a proposition did have legal implications for additional wage compensation⁵⁶, and introduced the possibility of collective bargaining for new economic benefits. This proposal was not totally approved, but a special wage compensation was included (Nivelación salarial). This decision had proved to be expensive for the public finances, both at the national and local levels.

Finally, it was also in the Senate, in plenary sessions, where an additional component was introduced related to supervision and control of the system. The roles of a *superintendencia*, information requirements, and control were defined. During that period, the ISS reorganization and the transition regime were also defined.

After the reform was approved and modified in the Senate, it went to the House of Representatives where a Commission that included the active participation of the Health Minister, studied the project. The process was faster than in the Senate, and generally they ratified agreements that had been reached before.

The main changes were the approval of the Benefits Package for relatives with similar benefits to those of the affiliate, using the figure of co-payments. The introduction of essential medicines in their generic form was approved even though when the pharmaceutical industry did not agree with this proposal. By the time the Law was discussed there was a national debate about the high and increasing costs of medicines, therefore they could not count on the backing of public opinion when pressing for their interests in the case of health reform.

⁵⁵ An affiliate is a person who pays a premium to enroll in EPS; an enrollee is a person covered by an EPS, it can be an affiliate or a family member of an affiliate.

⁵⁶ It introduced "*cesantias retroactivas*." That means that when a worker retires he has to be paid one salary for each year worked (*cesantias*), but in this case the payment would be based on the last year's salary.

During the debate in the House of Representatives, the Primary Health Care Program, was defined. This included public health interventions to promote health, such as immunization and AIDS prevention among others. This program was established as a complement to the Benefits Package and under government responsibility (though not under the social security institutions). Finally, more resources to support the reform were defined such as a new social tax on arms.

After the project was approved in the House of Representatives, a Conciliatory Commission with members from both chambers, Senate and Camera, and with the active participation of the Ministry of Health, unified the projects that had been approved in plenary sessions by both of them. This was necessary because the reform had been the result of controversy, and the final Law approved in each legislative arena had some differences.

On December 16, 1993, the Law was finally approved by the full Congress and a week later on December 23rd President Gaviria signed it. The Law that finally resulted combined many different points of view and most of the groups involved in the discussions, with the probable exception of doctors and public hospitals, seemed to feel that they are represented by the reform .

Finally, it is important to point out that Alvaro Uribe was the key figure in Congress. He was the most important conciliator between different positions and had a clear commitment to gaining the approval of the Law.

SECONDARY LAW FORMULATION

Law 100 gave enormous flexibility to the health reform. In order to set in motion the norms included in the Law, at least 25 regulatory decrees had to be prepared and issued. This secondary Law was made by the Ministry of Health, in consultation with the new CNSS, and they were eventually approved and signed by the President. It is important to point out that at this point the reform development no longer had to go through Congress. It was done at the Executive level under the control of the Ministry of Health. The process was not as pluralistic and open as it had been during the whole debate. The main focus of the Ministry during the eight months before a new government came into office (January-August 1994) was to advance the regulations as quickly as possible. This was seen as strategic. According to Londoño, “it was my belief that taking so much time could have brought the reform to a halt. Therefore, the strategic decision was made to develop the regulation as soon as possible (...) create new mechanisms for allocating additional resources and train as soon as possible the system’s new agents.”⁵⁷ The creation of the new National Health Board was speeded up for this purpose and between August 1 and August 5, 1994, the last week President Gaviria was in office, twenty-two key decrees were approved.

According to people working for the Ministry at the time, the process of secondary law formulation focused mainly on technical issues such as the creation of the CNSSS; the definition of new institutions within the system such as EPS, IPS, public hospitals, ESS, and FOSYGA; the definition of the system’s benefits through the POS, complementary plans, and the subsidized regime; and reform in public institutions such as the Ministry of Health and the Health Superintendency. They tried to resolve those issues in the most technical manner possible, and counted on the support of national and international experts, who played a key role in this part of the reform. The team working on the reform at this stage was modified. Although Londoño was still the leader of the process, the group was joined by several highly-qualified people such as Maria Luisa Escobar, Teresa Tono, and Beatriz Londoño, some of whom had been working in the technical developments of the reform since the period in which it had been discussed in Congress.

⁵⁷ Londoño, *Ibid.*

However, not all the issues of the reform were developed at this stage. Priority was given to setting in motion the new actors of the system, particularly for the contributory regime. But key points of the transformation were not defined, such as the incorporation of the people living in poverty into the subsidized regime and the transition from supply to demand subsidies, among others. Those issues later posed problems during the implementation process.⁵⁸

Officials from the Ministry of Health and the DNP argued that there were no fundamental changes made to the reform at this stage. However, other interviewees stated that the Ministry of Health did try to use the opportunity of regulation development to define more precisely some of the elements that were vaguely stated in the new Law. And this was done based on the principles the MOH group believed in: efficiency, the importance of the role of the private sector, the introduction of competition, freedom of choice, and financial sustainability. A key example was the curtailing of the Benefits Package that had been agreed on in Congress. Using cost-effectiveness criteria, high cost treatments without proven efficiency such as kidney transplant were excluded; ailments such as terminal illness would be treated with pain alleviation and at home; and aesthetic interventions were excluded. Also, according to some critics like Gonzalez Posso,⁵⁹ the development of the regulatory body for the new Law represented a return to a segmented system, since even though the Law mandates a single Benefits Package for both the contributory and the subsidized systems, in practice two different Benefits Packages were defined. He also argued that the development of regulations during this stage of the process, favored the creation and consolidation of the private organizations that were to participate in the reformed health system, but failed to put in place the right incentives for the transformation of the exiting public institutions.

Finally, although the Ministry consulted with the new National Health Board on the general topics of the reform development proposals (if not the details), the fact was that the board had neither the time, nor the technical instruments to discuss them.⁶⁰ In addition, during the process of transition to the Samper government, even when the new team wanted to know about the health reform development proposals, Londoño did not agree to their request. This was both an expression and a source of many tensions to come.

In August 1994 a new team came to power, with President Samper as the leader. Even though they also represented the Liberal Party, they had a different orientation and were critical of Gaviria's ideas of development and modernization. The group of people who had been at the ISS at the beginning of the Gaviria administration returned to power, with better positions and greater capacity to influence decision making.

THE IMPLEMENTATION PROCESS

The implementation of the reform began in 1995 under a new national government and also with newly-elected territorial authorities. According to the Law, the implementation of the reform had to start in January 1995. Since then, according to the Ministry of Health, the coverage of social security in health has increased from 23% to 54% by 1998; 66% (21.5 million people) are in the contributory regime

⁵⁸ Londoño, *ibid.*

⁵⁹ He was the second Minister of Health during Gaviria's administration at the beginning of 1992, and belonged to the M-19 group. He was an intellectual, not a guerrilla.

⁶⁰ According to Jaramillo the process of "*reglamentation*" of those months was demanded by the National Health Board and today they are the ones who establish Agreements that have the power of Law-Decrees.

and 33% in the subsidized regime.⁶¹ The resources for health have doubled and there have been significant institutional changes, such as the creation of 30 EPS (20 of which are private, 10 are public, and 1 is public-private⁶²) and of some agencies in charge of managing the health plans of the subsidized regime (ESS). On the other hand the funding of the public hospitals has changed from a supply subsidy to a demand subsidy.

Therefore, the reform seems to have had an impact on the expansion of coverage and institutional development. Nevertheless, certain tensions that were present in the definition and formulation of the reform, and that were not dealt with, arose during the implementation process. According to Londoño, the general nature of the Law “simplified the political negotiations in the Congress, but many of the potential conflicts that were brewing at the time, erupted in the period of implementation.”⁶³

The political process of the implementation has been very important in the outcome of the reform proposals. The tensions that were present during the reform’s formulation and legislation, have persisted during its implementation. In particular, the old actors of the reform have not changed as expected. This is the case with the ISS and public hospitals. At the same time, the reform created new groups interested in the health process such as EPS and ARS, which have been very dynamic. It also modified the status and interests of existing ones such as hospitals and social security institutions. On the other hand, the possibility of affiliation with the social security system has also created a new relationship with the health sector for many people.

The implementation process not only involved a different set of actors from that of the Law’s formulation, the institutional and organizational aspects have been also been a difficult part of the Law’s implementation. And they have influenced the outcome of the reform. The changes proposed have made important demands on information, organization, and management capacity. Those demands have been particularly difficult to meet, particularly for the public actors in the reform, and have affected the final outcome.

Many problems were encountered during the implementation process. One has been the resistance of the ISS and its difficulties fitting into the system, since this institution is still the main actor in the social security reform. Another has been the change of direction in the Ministry’s signals about the reform according to each new Minister of Health. There were three Ministers during the first 20 months of Samper’s government, which was accompanied by instability of officials with decision making responsibilities and very little continuity in the technical teams.⁶⁴ Other problems have been lack of information and low allocation of the resources from the Solidarity Fund, which belong to the subsidized regime. More important difficulties have involved making decisions about the transition of each of the agents in the old public system. The ISS, the departmental directorates of health, and the public hospitals have resisted change.⁶⁵

Resources to fund the reform seem to have been adequate, but the erratic policy, particularly during the first two years of implementation, led to problems in the execution of the reform. Apart from that, there had been problems with the definitions of technical issues such as the UPC, and difficult adjustment for some institutions. The transition from supply to demand as a criterion for

⁶¹ Minsiterio de Salud. *Informe de Actividades 1997-1998 al Honorable Congreso de la República*, Julio 1998, Bogotá.

⁶² Nevertheless, the ISS is the EPS with the most affiliates, representing 62% of the contributory system.

⁶³ Londoño, 1996

⁶⁴ Alonso Gómez (who stayed for one year); Augusto Galán Samiento (six months), and then María Teresa Forero de Sade (two years and a half).

⁶⁵ ASSALUD, 1997.

assigning subsidies, had led to overlapping resources, slower response in delivering services, and increasing costs.

There has also been passive resistance from the bureaucracy within the health sector's public institutions. However, there was also confusion and lack of information and assistance during the transition. This situation prolonged the transition of those public institutions that were hoping that each new minister would express opposition to the reform. Nevertheless, there have been countervailing forces in favor of the reform such as the CNSS, three loans with international Banks (IDB and World Bank), and the involvement of international organizations and foreign universities⁶⁶ as well as the dynamic generated by the private and territorial actors of the reform.

In relation to funding, during the first two years, the national government did not allocate the total amount of resources. The transfers from the National Budget to the FOSYGA to match the solidarity point paid by the contributory regime, has been made according to each year's initial estimation of resources to be collected. On the other hand the Cooperative Organizations (*Cajas de Compensación*) did not contribute as much as expected, because they argued that they should be involved in the system and should not allocate resources until the ISS had family coverage. This was a process that took some time. In addition, there was evasion in the contributory regime, particularly with the independent affiliates because they under-reported their income.

The contributory regime has had fewer problems, in spite of the fact that the ISS, which has still not made the proper transition to the new regime, remains the EPS with the most affiliates. There was some conflict with the pre-paid medicine companies who wanted to compete with the new social security system and attract clients for themselves.⁶⁷

Finally, there were some proposals to reform Law 100, 1993, that did not make much progress. For instance, there was a project from the Finance Minister in 1996 to return the health service monopoly for the subsidized regime to public hospitals and health authorities. There were also proposals in Congress, probably related to the need to rationalize public expenditure, to abolish the Government's contribution to the National Solidarity Fund and reduce the central government transfers in 50%. This would have also affected the subsidized regime, due in part to the financial difficulties the Government was facing. But it also represented the continuation of a position that saw the public sector as the main vehicle to reach the poorest.

Those were the general trends of the reform during the first two years of implementation (September 1994 - August 1996). Nevertheless, there are at least two different periods, one of them when Alonso Gómez was Minister and defined a transition period for the subsidized regime, and the other one under Augusto Galán Sarmiento and María Teresa Forero de Sade.

THE TRANSITION PROCESS

When Samper came to power he appointed Alonso Gómez as new Minister of Health. During his term in office the reform began to be implemented. The team that had worked on the health reform at the Ministry of Health was dismantled. Two members stayed, Nelcy Paredes and Beatriz Londoño, who remained for only a brief period. Alonso Gómez, the first Minister under Samper, was a doctor who had been the director of Hospital San José (a public institution in Santafé de Bogotá) and Samper's personal physician. He had been opposed to some of the proposals during the discussion of the reform. He believed in the role of the state and in concentrating resources in tertiary public care. In addition, he

⁶⁶ Londoño, *Ibid.*

⁶⁷ It seems that the number of affiliates to pre-paid medicine companies has decreased.

was critical about the process of secondary law formulation that took place during the last months of Gaviria's term of office, because it had been at the very end and the Samper team, including himself, had not been able to participate at this stage of the policy process. While he was in charge of the Ministry, his decisions generated confusion among the health reform actors given his position *vis a vis* the reform. Nevertheless, he counted on the support of doctors, the union of health workers, and public agencies, in his attempts to subvert, at least in part, the reform.⁶⁸ It is important to point out that to a certain extent this was consistent with the consensual strategy promoted by the Samper administration, in opposition to a more technocratic model of decision making.

According to most observers, as of December 1996 the reform was not operating in the case of the subsidized regime. The regional offices of health kept the EPS monopoly. In order to avoid inequity and inefficiency, Law 100, 1993 had authorized demand subsidies for hospitals, according to the population they covered and their level of poverty, through the ARS (Health Plans for the subsidized population).⁶⁹ But because it was not convenient to make those changes in an abrupt way, a transition regime was established by the Law.

In November 8, 1994, one year after the approval of the Law, a transitional regime was established (Decree 2491, 1994), in order to facilitate the change from the old system to the new one proposed by the reform. The decree authorized the territorial health authorities to become EPSs to administer the subsidized regime while the new EPSs were being created. In the case of hospitals, a tariff system was defined and a reimbursement system for those services that they would have to provide free for the poor. Nevertheless, there were no visible signs promoting the consolidation of EPS that could run the subsidized regime, introducing competition, or beginning to change supply subsidies into demand subsidies. In addition, the Minister had excluded 67 Cooperative Organizations, 142 ESS, and 13 EPS that already existed at the time from administering the subsidized regime.

This decree generated a great deal of controversy. It implied a reversal in the demand subsidies in favor of the supply subsidies. It changed the allocation of resources from the UPC to a tariff system. It also subverted the principles of efficiency because the functions of insurance and funding were again combined in one agency, as well as the responsibility for public health provision and management of health. It eliminated the concept of social security in the case of the subsidized regime. Finally, this led to a situation in which hospitals were receiving demand as well as supply subsidies.

According to some observers, Gómez tried to undermine the sense and credibility of the reform and to radically change its nature. However, after one year in office he was replaced, because he lost support from doctors and health worker's unions. In addition, groups that had been critical of the reform during the debate, nevertheless thought that the Law was the final result of a process of consensus building that had gone through all the negotiation stages that the country had, and therefore it should be respected. Finally, the President was also advised by some of his ministers such as Cecilia López (Environment), José Antonio Ocampo (DNP), and Guillermo Perry (Finance), to replace Dr. Gómez (Interview, August 4, 1998).

⁶⁸ Alonso Gómez is a psychoanalyst who had worked in intensive care. He was Samper's personal physician when Samper suffered an assassination attempt during the 1980s. These facts help explain how he became a Minister and why his main interest was public hospitals and medical specialists. Alonso Gómez did not feel well treated by Londoño during the transition between governments and it seems that an offer from Londoño to make him his deputy Minister had not been approved by Gaviria.

⁶⁹ Such as "*Cajas de Compensación*", ESS, and EPS

FIRST STEPS TOWARDS REFORM CONSOLIDATION

In July 1995, Augusto Galán Sarmiento was appointed new Minister of Health. He came from the “galanista” group of the Liberal Party, and the support of that faction was useful to President Samper. He believed in the health reform as a social project.⁷⁰ His time in office was very limited, lasting until the beginning of 1996, when he decided to resign as a result of allegations about the funding of the Samper presidential campaign with resources from the drug barons. For some observers, because of this short period as Minister he did not have the time to do anything significant. For others, however, he was key in putting the reform back on track. In December 1995 he promoted Decree 2357 that corrected the problems generated by Decree 2491, 1994, which was seen by many as a counter-reform, in relation to the transition of the subsidized regime. The new decree authorized the Cooperative Organizations, the EPS, and the ESS to manage the subsidized regime. This new change of direction was supported by the growing consensus among specialists and groups that had participated during the reform process to develop the principles established in Law 100, 1993.⁷¹

At the same time, however, Alonso Gómez, who had subsequently been appointed Presidential Advisor on Health Topics, promoted the creation of a Presidential Program for Hospital Development. This new program was based on principles contrary to elements of the reform such as state authority over hospitals as well as ministerial and local authority and autonomy. For those reasons as well as resistance and lack of clarity, the changes of direction did not have clear results until the second semester of 1996, when María Teresa Forero de Sade was already in office.⁷² She was the third Minister of the Samper administration with previous ministerial experience and her previous job has been as ACEMI director. She stayed in office until the end of his government. During her period as Minister the reform started to be consolidated after two years of delay. According to health analysts, what she did was not to take new radical decisions, but rather to implement what had already been decided. However, at this point, it is still too early to arrive at a final evaluation of the process. What may be happening is a consolidation or it may be yet another phase of the reform process that might change course or even revert to an earlier stage.

CONCLUSION: KEY POLICY NODES AND ACTORS

The Colombian social security reform, including the health reform, approved by Law 100, 1993 was an ambitious and complex transformation that was undertaken during a period of state reform. The process of definition and approval of the reform took three years of intense negotiation and development of technical expertise in health. President Gaviria has stated that it is probably the most important social transformation during the second half of this century.⁷³ Nevertheless, the Health Reform was not the direct result of his initial idea about the social security reform. As Jaramillo (1994) has pointed out, the health reform was probably the price that the government had to pay to approve the pension reform.⁷⁴

⁷⁰ He is brother of Luis Carlos Galán Sarmiento, a Liberal leader assassinated in August 1989.

⁷¹ Fedesarrollo, 1995.

⁷² She is a doctor with pediatric specialization but with previous experience in the public sector. She had been a Minister before.

⁷³ Hommes et al., 1994.

⁷⁴ Jaramillo, 1997.

Law 100 reflects an international trend on social security reform, but the context, the formal and informal institutions, and the main actors involved, made it particular to the Colombian situation of the early nineties. The Law was the result of an intense debate where many “policy nodes” were important: the Assembly to amend the Constitution between January and June 1991; the Social Security Commission established by the Constitution to define the basic points of a social security project (July-December 1991); the reform formulation (1992); the Congress with its different stages: commissions, plenary sessions, conciliatory process (1993); the drafting of the decrees needed in order to develop the reform (January-August 1994); the transition decrees (1995); and the implementation.

Because there were many policy nodes and because the reform generated intense discussion, the final result was the combination of many different positions. The main tensions were always between the ideas of solidarity and efficiency, and the final result is the inclusion of both as the main principles. This debate was constant from the drafting of the new Constitution until the reform’s implementation stage. The other tension present during the whole process is one between the roles of the public and private sectors. The relation between the State, market, and society, was redefined in relation to the health services and a combination of public and private systems was defined.

Finally, even when the reform is the result of a consensus, the team of the Ministry of Health did have space to maneuver within the reform process and increasing technical and managerial expertise were required. In relation to the actors involved, they changed according to the stage of the process. During the formulation, the main actors were the members of the National Assembly to amend the Constitution and the Social Security Commission; the teams from the National Planning Department, the ISS and the Ministry of Health; unions and think tanks. Nevertheless, when the proposal is presented to the Congress, the Ministry of Health takes the lead and this continues until the implementation process. The character of the Ministry of Health team changed being increasingly technical during the secondary law formulation process.

Other important actors during the whole process were representatives from territorial health authorities, unions, congressmen, medical associations, health technocrats; private research institutes; health workers; people who represent the Cooperative Organizations, Pre-paid medicine, producers and industrial associations, pharmaceutical organizations, and politicians. But the users of the system, the consumers, were not represented either in the case of the contributory or the subsidized system.

Finally, it is important to point out that at the heart of the process there was a small group of people that, under Juan Luis Londoño’s direction and with the support of the President and others in the government and outside, was able to make important contributions to the decision making process.

The final outcome of the reform continued to be the object of many arguments during the implementation. However, different groups that participated during the formulation and approval by Congress of the health policy changes, felt their proposals were somehow represented there. Rudolph Hommes, Finance Minister, stated in an evaluation of this period’s policy process: “In health, this government, taking advantage of the social security reform project, has proposed a revolution that, for the first time in Colombian history, will make possible access to basic health service for the people living in poverty” (Hommes, 1994). President Gaviria himself said that Law 100, 1993, was probably the most important one in the second half of this century (Hommes et al., 1994). One member of the ISS-Consenso group, who was opposed to many aspects of the official proposal says: “we felt represented with the final outcome of the reform, that introduced universality and solidarity principles. This is the reason why we have defended the reform against the resistance during the implementation process (Interview, Aug 4/98).

III. THE USE OF CHANGE TEAMS AS A POLITICAL STRATEGY

INTRODUCTION

The process of health reform definition, formulation, and legislation generated intense discussion in Colombia. The bill finally approved represented a consensus among different and even contradictory positions, including those in favor of the market and competition as well as those in favor of maintaining solidarity and a significant role for the state. The Law is the expression of different views within government, congress, the academy and civil society. The final result is a health system based in social security mechanisms which involves both competition and the private sector, while maintaining the role of the State and public agencies not only as regulators but also as providers. On the other hand, it is a system that includes solidarity instruments such as the same Benefits Package (*Plan Obligatorio de Salud*) for both regimes; a risk per capita unit; and para-fiscal solidarity mechanisms. However, the combination of those points of view was already present when the Executive presented the bill proposal to Congress in March 1993. After that moment, the change team, in spite of many debates, was able to develop the health reform proposal without significant modification, with the exception of an integral Benefits Package for both regimes.

The reform had to pass through different institutions and different arenas; therefore, its final content was modified by the Constitution, the Social Security Commission, the Congress (with its two chambers), and the formulation of secondary law (“*reglamentación*”). The reform was a comprehensive one, and was approved during a short period of time. The process of reform began in 1991 with the discussion and promulgation of the new constitution and, even when the implementation continued after that date, it is possible to argue that the reform effort as such ended in August 1994 when the Gaviria government left office.

Even when the reform was the result of a particular context and specific institutions that partially determined the possibilities and process of the bill, there was a change team from the policy elite able to introduce policy change. At the beginning of 1993, this team presented a proposal that was already towards the center of the debate. They were able to do this because of their technical convictions, but also by taking into consideration the political aspects of the health reform. The team was able to maneuver and define aspects of the content of the reform. Thus, the team used strategies to have the reform approved and they influenced the content of the reform. Their power was based on both their technical knowledge and also in the particular networks they built across sectors and different levels of authority within the State, particularly in their vertical networks. In addition, the change team had scope to define particular issues that eventually proved to be very important, such as the existence of two regimes, the UPC, and competition in health affiliation and provision, but with the existence of the FOSYGA.

There seems to be evidence to show that within limits there is scope for government to introduce significant policy changes. One of the successful strategies that governments have used to introduce reforms is precisely the creation and support of change teams. This was a strategy used in Colombia first for the introduction of economic reforms, and then later replicated for social reforms, which usually involve a more pluralistic process than those related to economic policy.

Change teams are comprised of people called by decision-makers in a particular moment to pursue specific policy changes. They are limited by the context and the institutions of their particular moments and countries, but they have scope to maneuver, based on the political support that decision makers give to them. This enables the group to design and promote reforms, even in the face of

opposition from actors and interest groups with direct political support. This was especially true in the case of the Colombian health reform.

The main objective of this chapter is to describe the change team in the case of the Colombian health reform: who they were; what were their motivations and ideology; and particularly what were their main strategies to achieve results with the health reform. The analysis is developed through describing the horizontal, vertical, and cross-society networks they established and identifying other strategies they used. The hypothesis is that the State, within limits, has the capacity to promote change and one of the possible strategies is the use of a change team. A successful change team has two main characteristics: it is highly technical, but it has to do political maneuvering to achieve results.

It must be pointed out, nevertheless, that the health reform in Colombia is still an on-going process and far from finished. The formulation and legislation have been done, but the implementation and adjustment of the process continues and there are different actors in each phase. However, for the purpose of this research, attention was focused on the period when the reform was defined, formulated, and approved in Congress and when the initial regulation package was formulated.⁷⁵ The role of the change team is clearer in that critical period of policy formulation; particularly between November 1992 and August 1994.⁷⁶ This is true even when the reform itself involved a longer period: beginning with the promulgation of the new Constitution in 1991 and continuing through early 1996 when it reached the first stage of consolidation.

CHANGE TEAM CHARACTERISTICS

During the health reform, a close group of policy makers and technicians can be found at the Ministry of Health headed by the Minister. It is recognized as the change team by its members and by outsiders, both at the Ministry and other arenas. Nevertheless, the group is dynamic and changes over time according to the health reform process.

It is important to bear in mind that at the time of the health reform process, there was already a context of institutional change led by President Gaviria and an economic change team which had been in charge of different reforms in the areas of finance, taxation, foreign exchange, labor markets, and housing. The main orientation of the country's structural reforms was towards liberalization and internationalization. The main figures of that economic team were Rudolph Hommes, the Finance Minister, and Armando Montenegro, the Director of the National Planning Department. Juan Luis Londoño had been part of that team as the National Planning Department's Deputy Director. The economic change team had also been involved in the labor reform and they were very interested in the pension reform that was part of the social security reform of which health was a component.

As described in Chapter II, the period leading to the submission of the health reform in Congress was one of important discussion, with many groups involved, some of them with very different positions. But a change team as defined for the purpose of this study was configured in November 1992 when President Gaviria appointed Juan Luis Londoño as Minister of Health. From this moment, he became the leader of the process of health reform until August 1994. He was also the head of the

⁷⁵ Secondary law formulation is the process by which a regulatory body is formulated after each bill is approved by Congress. In the case of the Law 100, 1993, this process was in the hands of the Executive, particularly the Ministry of Health and the President.

⁷⁶ This period includes the process of the law's discussion in congress, as well as the promulgation of the regulatory decrees.

change team. Although the reform involves a longer period, this is the time when a change team can be identified for the first time. The team that worked with Juan Luis Londoño during this period was a very small one and had at least two stages (with some overlap): one, during the process of formulation of the proposal and its discussion in Congress, and the second during the decree promulgation period.

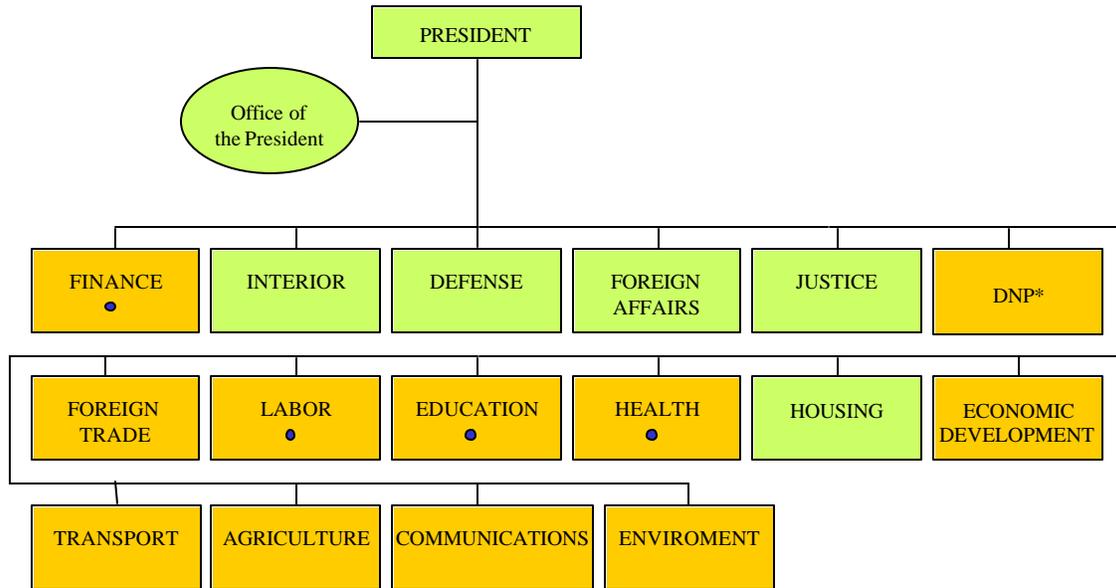
During the first discussion about pensions reform, when it became clear that Congress was going to condition the approval of the new pension law on a similar in-depth effort in the health sector, a team of highly technical policy makers from different ministries was commissioned by the President to study policy options for a health reform. This team became an important precedent to what was to become the change team in health. Some of its members became central to the change team; the others remained as members of horizontal networks. The team was comprised of individuals from different institutions as a mechanism to create consensus among them. From the National Planning Department the members were Juan Luis Londoño, the Deputy Director, and Nelcy Paredes, the Social Development Unit Director. The Ministry of Health was represented by Ivan Jaramillo; Luis Eliseo Vazquez represented the ISS; and the Ministry of Labor was represented by Mauricio Perfetti, advisor to the Minister. These individuals all played an important role at the beginning of the process, but only Londoño and Paredes remained as part of the change team and were absolutely central to the process of health reform when they went to work at the Health Ministry.

It is during the period of formulation and discussion of the bill in Congress that the change team becomes clearly identifiable. Initially it was comprised of Juan Luis Londoño as the leader and Nelcy Paredes as his main assistant. They built important links with key members of Congress, the Executive, and other groups in and outside the government. At this stage the process of reform was open to discussion and the President's commitment and support was very important. The fact that the team came from the DNP gave it credibility *vis a vis* other policy makers working on the State reform proposals and crucially with the economic team in government.

During the second phase of the reform—the decree promulgation process—the team was enlarged and some of its members became highly specialized. They built important networks within the Ministry and with health specialists as well as with the international community whose support was very important. Juan Luis Londoño was the leader of the change team. The other key members were Nelcy Paredes, Maria Luisa Escobar, Beatriz Londoño, Oscar Emilio Guerra, Diego Palacios, Teresa Tono, and Edgar González. On a second level of closeness were Wolfgang Munar, Eduardo Alvarado, and Iván Jaramillo.

Chapter 3 – Diagram 1

COLOMBIA
STATE REFORM 1990-1994



● Former members of the economic team

■ Reformed Sectors

*Planning Department

**Indicative, non comprehensive diagram.

It is possible to distinguish two stages in the change team strategies during the formulation of regulation: the first one from the promulgation of the Law in December 1993 to March 1994, when the technical work and technical definitions were the most important issues; and the second one from April to August 1994 when the work was more results-driven and more decisions had to be made. This was done to leave the regulation package as advanced as possible before the new government came to office, in order to guarantee the survival of the reform according to the change team’s criteria.

At this second stage the political aspects of the reform had to be taken into account and the technical aspects lost some of their salience. The members of the change team gained and lost influence according to the salient issues at different stages: although the technical ones stayed, the decision makers, the brokers, gained more influence during the second stage of the secondary law formulation.

THE CHANGE TEAM’S CONFIGURATION

During the whole process, Londoño recruited the change team with the support of Diego Palacios, who also became one of the change team members. Londoño brought in people with technical training, giving priority to those who had studied abroad. In the beginning, experience in government was not considered an important asset.⁷⁷ The members, by and large, lacked political support. The team was small and comprised of consultants who worked directly with Londoño and did not depend on the Ministry of Health. They were not planning on joining the Ministry of Health or working for the

⁷⁷ Later, this was seen as a handicap during some moments of the reform development.

Government, rather, they were persuaded by Juan Luis Londoño's charisma and powers of persuasion to join the team, thinking that tangible changes could be attained for the country.

Juan Luis Londoño had studied Business Administration in Medellín, Colombia, his hometown. He later obtained a M.Sc. in International Economics and Monetary Theory at Universidad de los Andes, Bogotá. He also earned a Ph.D. in Economics from Harvard University where he concentrated on income distribution in Colombia under the supervision of Professor Jeffrey Sachs. President Gaviria appointed him as DNP deputy director in August 1990. At the time, like many other people that President Gaviria appointed, he was a young technocrat without much experience in policy making. He became Minister of Health in November 1992. After leaving government with the arrival of the new administration, he went to work for three years in multilateral organizations as senior health expert (World Bank, IADB). Upon his return to Colombia in 1997 he assumed the direction of a business and economics publication, *Dinero*, and he continues to play an important role in public debates particularly related to economic and development topics.

Juan Luis Londoño has many of the characteristics that Domínguez (1997) identifies in a "technopol." He is a technocrat with international reputation, he is an optimistic and he is an innovator. He is considered a neoliberal. Nevertheless, within the "neoliberal group," he is the one who has worked on such issues as human capital, education, income distribution, and health. According to a member of the change team: "Juan Luis is not a neo-liberal, his area is human capital; he believes in the market but in regulated competition. He is a man in the center." (Interview, November 3, 1998)

Even though before becoming Health Minister his main interest was not health, Londoño had been concerned with the social infrastructure component of the National Development Plan. This component included the basic principles for the social sector strategies during President Gaviria's administration such as demand subsidies, a greater role for the private sector, competition mechanisms, and targeting. Through his position as DNP deputy director he also had access to the policies being developed by international organizations, related to social policy. A case in point was his familiarity with the debates around the World Health Report by the World Bank, published in 1993. Even when his previous experience within the social sector was mainly in education, when he was assigned to health, he approached it as another important social sector in terms of human capital and its impact on development. He believed that the main point was his approach as an economist to health, which could have much in common to his approach to education.

In his capacity as Minister of Health, he approached experts like Julio Frenk and Philip Musgrave, national health specialists such as Francisco José Yepes and Iván Jaramillo, and groups with experience in health issues working in the private sector. He had both technical and political abilities, the latter probably developed mainly as DNP Deputy Director, but particularly as Health Minister in charge of the Health Reform. As Health Minister he was the leader of the Health Change Team. He maintained ties with the economic team and was always backed by the President. In addition to his technical abilities, he was able to take into consideration other factors in the decision making process such as the political and institutional feasibility of the technical proposals.

Nelcy Paredes was his main assistant during the whole process. She studied economics at the Universidad Javeriana - Bogotá. As Health Division Director at the DNP from 1983 to 1992 she had important knowledge of the health sector, its key interest groups and members, and the decision making process. This knowledge of the sector made her a key member of the team. She was considered mainly a conciliator and a broker between technocrats and decision-makers. She was aware that the health reform process was both a technical and a political process. In 1992 she became the Social Unit Director and had participated in the health debates that were on-going since the discussion of the new Constitution. Soon after Juan Luis Londoño was appointed Minister he asked her to work directly with him on the health reform project. She worked first as his main assistant during the

formulation and discussion of the Law in Congress, and then as coordinator of the change team during the secondary law formulation processes. After the reform and, in part, at a request of Juan Luis Londoño, she stayed at the Ministry of Health for most of the 1994-98 period. Later, she went to work for ACEMI, the paid-medical organizations association.

Paredes' role was crucial during the whole process. She talked to many people in the Congress: high and medium level technicians working on the reform; members of the Congress and their assistants; and interest groups. During the secondary law formulation she was mainly a broker, who also had an impressive knowledge of the sector (Interview, October 7, 1998) Her networks with different actors, were very important in increasing the feasibility of the health sector reform. During the development of the Law she was also the main coordinator of the team.

Maria Luisa Escobar was working for the IADB when she met Wolfgang Munar, then Health Deputy Minister. When the health reform proposal was still being discussed in Congress, she joined the team and started to conduct highly specialized studies, as a strategy to anticipate the technical demands that the implementation process was going to have. She is an economist and was in charge of technical aspects of the reform. She played an important role in defining topics such as the Benefits Package content and the DALYs. Upon her arrival at the Ministry of Health she put together a large team of young economists who concentrated on the most complex and technical aspects of the reform, in complete isolation from other change team members, the Ministry of Health bureaucracy, and interested groups outside the MOH. As a member of the change team she was also important for being a technical interlocutor with other actors that intervened in the reform discussion, giving the process technical legitimacy. After August 1994 she returned to Washington, D.C., and joined the World Bank.

Teresa Tono was a postgraduate student doing a Ph.D. in Health Administration at UCLA when she met Juan Luis Londoño. He asked her to join the team that was in charge of developing the regulatory package, particularly the topics related with the institutional development of the new actors in the reform, such as the EPS. In January 1993 she became a member of the team. Her most important role was played at the beginning of the decree development process. She is a doctor who had worked for the SER Institute, a Colombian think tank that used to be strong in social policy issues during the late eighties. After the reform, she went to work for the FES foundation in Bogotá, on topics related to health.

Beatriz Londoño is a doctor with a specialization in anesthesiology and with clinical experience. She earned an M.Sc. in Public Health from Harvard University. Before joining the team most of her experience was in Central America and the U.S.A. She was at the University of Antioquia, Medellín, when Juan Luis Londoño asked her to join the team. He had known her vaguely at Boston when they were both students at Harvard University. She joined the team because she thought that there was a process of "building a new country" of which she wanted to be a part. She came to enrich a group that was mainly composed by economists, with her knowledge as a public health specialist. She was also motivated to join the team because it had academic excellence. Nevertheless she thought the priority during the process was to achieve results (Interview, November 15 1999).

Beatriz Londoño combined her standing as a medical doctor with her academic training and work in the public health sector. She was very effective, especially in maintaining good public relations. As a doctor, she was particularly valuable for the team's legitimacy *vis a vis* the medical profession, who saw them as outsiders and lacking "hands-on" knowledge. She also was able to articulate the feasibility of policy options, based on the technical issues developed by other members of the team. (Interview, October 7, 1998). Her role within the team became of increasing relevance and she has been the most important actor of the change team during the implementation process.

After the reform Beatriz Londoño became Health Secretary for the municipality of Bogota where she appears to have been successful in implementing the reform at the local level. She was ratified in her position by the new mayor in 1998 and had been mentioned as a possible Health Minister. She used the change team strategy for the implementation of the reform at the local level. Because she was in office for four years, she was able to work on institutionalizing the policy changes.

Oscar Emilio Guerra, the Health Superintendent between 1993 and 1994, was another member of the change team both during the discussion of the law in Congress and during the decree promulgation process. He became Health Superintendent through Juan Luis Londoño's influence. Oscar Emilio Guerra is a lawyer, who had credibility with the economic team in government, due to his experience in the financial sector as member of the Banking System Superintendency and then Director in charge of the "Superintendencia de Valores." Jorge Elías Melo, who at the time was Deputy Finance Minister, recommended him to Juan Luis Londoño.⁷⁸ Some members of the team agree that he was a key person during the whole process. "Juan Luis did not do anything without the final revision by Guerra" (Interview, Nov 12 1998). He himself advised the change team in legal matters during the whole process, and the team of lawyers who supported the process within the Ministry of Health came through his recommendation. He became a key player in the reform because he was the main articulator between the health reform technical proposals and the Law.

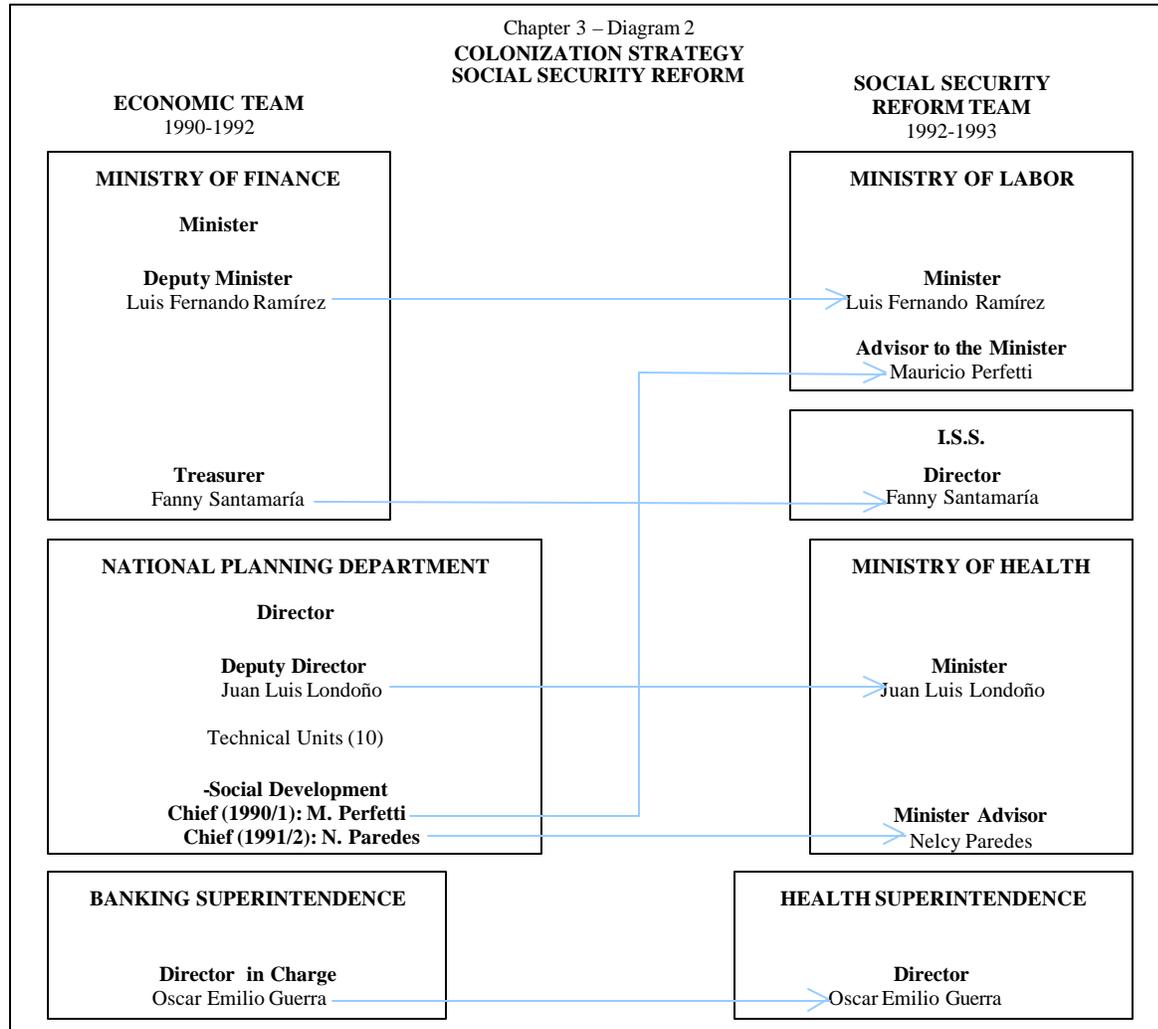
Edgar González, was General Secretary within the Ministry of Health and also played an important role as a member of the change team, particularly during the discussion of the Law in Congress. He was working at the MOH before Londoño came as Minister and to a certain extent he did not share the change team's ideology completely. Nevertheless, he was considered by Londoño to be part of the change team. His expertise was public administration. During the formulation of the secondary law, his main role was in the development of Law 60 /1993, together with Iván Jaramillo. It is important to point out that during 1994, the MOH was involved not only in the Law 100 development, but also in the Law 60 decree formulation. The development of this bill was also an important strategy because it was the mechanism to ensure that the new resources of decentralization would benefit the health sector.

Diego Palacios was also part of the change team. He was Juan Luis Londoño's assistant and the main channel in hiring the new team for the Ministry; he was also an important resource for the change team in administrative matters and an important mediator between its members. But his main role within the change team was his expertise in communication. He was a doctor with public health knowledge and specialized in communications. He developed media campaigns on television and radio and in the newspapers around topics such as AIDS and other public health matters. This was important in putting health on the public agenda at the time the reform was being discussed and developed. This communication strategy was very effective in gaining public support for the team in charge of the reform.

This group, under Juan Luis Londoño's direction, was the change team during the reform process. Their expertise went beyond technical skills was much more than the technical one, even when for outsiders at the core of the process were the health specialists. But within the team, it is clear the importance of people with different kinds of expertise such as communication, legal knowledge and public sector expertise.

⁷⁸ After the Law was approved in Congress, Melo became Labor Minister

As it is possible to see from this description, more than half of the people in the change team did not have any previous public policy experience and were not considering a career within the government. They came to the team by chance but motivated by a “sense of mission”, the possibility to change things and to work in a team of excellence. Most of the members of the team were highly qualified and with academic experience abroad and an international background. Because of their credentials and their international networks, the team, but particularly Londoño, had the capacity to gather around the best



academics working in health topics in the developed world. They did not have any personal political support and their legitimacy was based on their technical and professional credentials and their role as part of the team, which in turn had the support of the President and the economic team within the government: this situation explains their lack of commitment with particular groups and thus the capacity to base their work mostly in technical criteria. It also explains why they see themselves and their role as entirely apolitical.

CHANGE TEAM IDEOLOGY

The ideology of the change team was consonant with that of the macro-economic change team and President Gaviria himself. It was related to the modernization principles established in the “Revolución Pacífica,” the 1990-1994 National Development Plan. Within the change team there were only two positions that resulted in the particular way in which the reform was approved: those in favor of a public health sector, versus those in favor of the market and the private sector. Within the team there was a common ideology, in which the later position prevailed.

The change team had a particular ideology that was important in defining the way they acted and their ideals. They were convinced of the importance of taking advantage of the role the private sector could play in the provision of health services and they conceived of health as an element of human capital development. They built their approach to the health sector reform bearing in mind the possibilities given by two facts present at the moment: the promulgation of Law 60, which allocated new resources for health at local level; and the availability of mechanisms to increase efficiency in social expenditure that were being developed in different sectors such as targeting and demand subsidies. “We thought that the health sector needed a change; we firmly believed that the role of the state in health had to change: the state needed to concentrate on regulatory matters and should not be a direct provider in any case. We knew that we had to take advantage of the possibilities of Law 60 1993, and the resources that were made available as a result of that reform on territorial competencies and resources, and we had to design efficient mechanisms to use them.” (Interview, Nov 12 1998).

Related to the issue of the need for qualified human resources, again, even when they had the idea that it was important for the implementation of the reform, they did not give priority at the moment to an implementation plan for the reform, probably due to the lack of time and the priority they gave to the outcome of the reform. The team concentrated mainly on the outcomes of the reform, but not on the process to achieve it. “We were always thinking about the final results we wanted to achieve through the reform, but we did not really think and realize how difficult the implementation process could be.” (Interview, November 12 1998).

The other important point common to the team was that, even though the lack of information was a handicap some times, they tried to be as technical as possible. This was supported by the aim of having the best experts in health matters, not only from Colombia, but also from abroad (Interview, November 5, 1998).

For some members of the team, being pragmatic and result oriented was very important. Being optimistic and thinking that everything was possible was another characteristic of some members of the team. Others, probably the more academic ones were more skeptical about the possibilities of the reform. They all shared the idea that a different country was possible—that the process of modernization and having technocrats in power could make a difference in shaping that country. They were ready to take risks in order to achieve change. The technical knowledge was seen as superior and with more legitimacy than the role of the traditional politicians. Nevertheless, the individuals who headed the change teams in the state reform and health sectors were more conscious of the political roles they were playing. This was certainly the case with Hommes, Montenegro, and also Londoño.

On the other hand, due to the speed of the process, particularly during the secondary law formulation, there was not much time or space for discussion. Members of the team and people around them raised topics like the institutional feasibility of the reform, particularly at the local level, but in the end the issue was not discussed enough. There were also internal discussions on the poor quality of technical information available to them that they needed for the reform in order to make the best and most informed decisions.

But in the end, as a result of the short period of time available to develop the Law, pragmatic arguments were the basis of a process seen as merely technical from the outside. Most of the time the different opinions were resolved in a vertical manner by Londoño. “There were also things that brought us apart: for instance, to what extent the legal requirements could be translated into norms that could be effectively reinforced according to the reform principles? To what extent the optimal technical possibilities were possible in a country like ours? to what extent other international experiences that we were able to study through the literature were possible here?” (Interview, November 12, 1998).

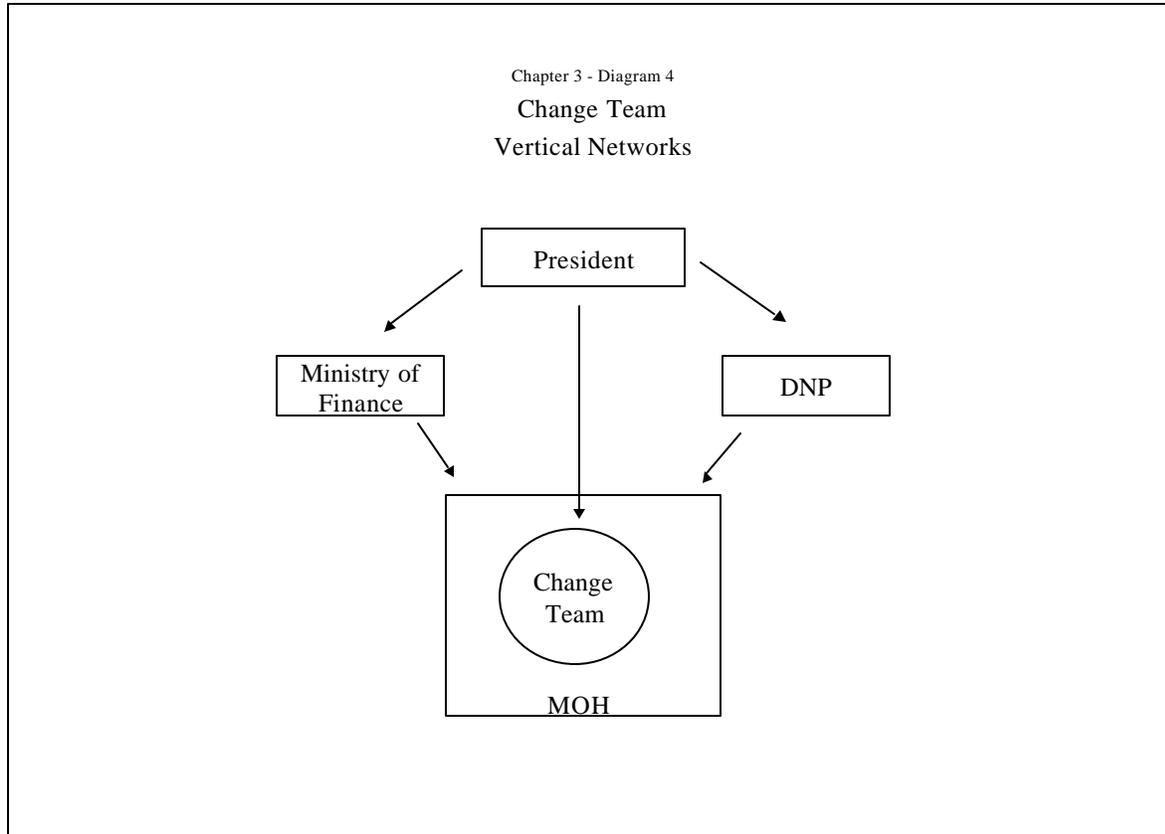
During the decree promulgation process, the change team was more isolated. This stage was under the Executive’s control and they did not have to make consultations or concessions as was the case during the legislation process. From the point of view of the members of the change team, because the main criteria for decision making were based on technical arguments that they assumed were correct, consultation was not seen as something necessary. This was only done when it was compulsory (such as the process of the health reform in Congress) or when it was considered useful because the change team needed information and needed to validate certain proposals. But most of the time the change team determined the people or the groups to consult during the development of the law. “In relation to consensus building, in a process like that you do not know to what extent it is desired. In general, that could be the ideal situation; but in practice, it may lead to loose or relax the key points you want to achieve, and people will always feel they are not sufficiently or legitimately represented by those who were consulted.” (Interview, November 12, 1998).

The members of the team had an apolitical self-image. “We were a very isolated group and it was not possible to put pressure on us. We were moved basically by technical and rational ideas, not by pressure groups.” (Interview, November 3, 1998). The team also felt that the technical aspects of decision making were more legitimate than the political ones. But having made that distinction, it is important to bear in mind that there were groups that did have access and influence with the change team. “During the formulation of the secondary law process we contacted the organizations that could become EPS, not because they were putting pressure on us, but because we needed to discuss with them the design of the process. In that sense we had contacts with Medical Co-operatives such as Coomevas and Susalud which were institutions that had a lot of information that was very important for us. During the development of the Law there was not political pressure....well, probably some members of the congress who gave important support to the reform tried to ensure something for them but Juan Luis Londoño isolated us from all that process.” (Interview, November 3, 1998).

CHANGE TEAM NETWORKS

VERTICAL NETWORKS WITHIN THE STATE

The main vertical networks the team had through Juan Luis Londoño were represented by the support of President Gaviria himself, the Finance Minister, and in some cases the National Planning Department Director. Londoño was an insider in this team, therefore he was seen as someone with legitimacy by them.



According to an interview (August 23, 1998) once the Congress imposed the formulation of the health reform as part of the social security bill, President Gaviria started to back the reform personally. For him, the law had high priority, even though in the beginning his main interest was the pension reform. For instance he himself organized meetings at the Presidency with members of the Congress in charge of the reform and he was the promoter of an agreement between the leaders of the traditional parties to have the reform approved by the Commissions that were discussing the reform within the Congress. The support of the President for the technocratic teams—the macro-economic team as well as the one in charge of pensions and the one in charge of the health reform—was a decisive feature for the approval of the health reform.

During the formulation of the secondary law, Gaviria also backed the team. The process of decree promulgation was handled by the Minister of Health who formulated the decrees in consultation with the CNSSS. President Gaviria signed them directly and with the necessary speed to have them ready before the Samper government came into office.

In the case of the Finance Minister and the National Planning Department, there was support because Juan Luis Londoño was an insider on the original team that participated in the modernization reforms, and all of them shared similar ideological terms. However, there were moments of tension as a result of the need for new resources for the reform, both fiscal and para-fiscal. For the health change team this was necessary in order to be able to offer universal coverage with an integral package; for the macro-economic change team the priority was the impact those measures were going to have on fiscal matters. However, what was most important was that this problem could be solved because the health change team had the capacity to argue in favor of the financial feasibility of the reform, based on its knowledge of public finances and the economic impact of the proposal. The relationship

between the macro-economic change team and the health change team was favored by the fact that they were able to share the same language and their mutual respect and trust.

The main interest of the economic team in relation to the social security bill was the introduction of the pension reform, but they saw in the process of health reform an opportunity to transform the health services in Colombia by introducing principles of efficiency and competition. Juan Luis Londoño, as the person in charge of the team, shared these principles with the modernization team, and they could trust him. The health change team was also backed by the President once he was convinced of the health reform as part of the social security reform. In some cases he supported them even against the arguments of his economic change team.

HORIZONTAL NETWORKS WITHIN THE STATE

In addition to the vertical networks that gave legitimacy to the change team, they also established horizontal networks that were important in the process of reform.

During the debate of the proposal in Congress, the change team worked with the group that was in charge of the pension reform, particularly the Minister, Luis Fernando Ramírez, and Mauricio Perfetti, his main assistant.⁷⁹ Even when each section of the reform was discussed separately, there were occasions when both groups came together and some times they shared the same strategies and built the same alliances. For instance the Labor Ministry took decisions and promoted actions in favor of both sectors such as getting the initial approval for the Law in commissions during May 1993, through negotiating with Congress with the direct support of the President (Interview, August 23, 1998). Another key factor was that the health change team tried to leave the political aspects of the reform in the hands of the Ministry of Labor, maintaining for themselves the technical role.

People working in the change team also felt they had the support of the Finance Ministry through Hommes, but also through the Technical Deputy Minister, Ulpiano Ayala, and his assistant, Mónica Uribe. Ayala was the person in charge of the social security reform within the Ministry of Finance and he played a very active role particularly in the pension reform. He left his post when Samper came to power, but Mónica Uribe stayed and she has been a key link in the horizontal network not only during the process of formulation but also during the implementation stage. "She was very important even when she developed an independent position from the one prevailing in the Ministry of Health" (Interview, November 5, b 1998).

After Cecilia López left the ISS, people who were part of this institution also became important members of the horizontal network, particularly through the Director, Fanny Santamaría, and José Eliseo Vázquez. They shared the governmental proposal of social security reform and participated in the process at Congress. During the decree promulgation stage they focused their work in trying to prepare the ISS for the changes to come, but their relationship with the Ministry of Health was less important at this moment. The Ministry was focusing on the consolidation of the new actors of the reform (particularly the private ones), instead of on the transformation of the existing ones. However, the de-activation of the initial group resistant to change within the ISS and its replacement with one sharing the same vision as the economic change team was a key factor in maintaining unity within the government and presenting a single front *vis a vis* the groups opposed to the reform.

⁷⁹ Mauricio Perfetti, is an economist from Universidad Pontificia Bolivariana de Medellín, with an M.Sc. in Economics from los Andes University, an M.Sc. in Public Policy from Oxford University, and a Ph.D. in Economic Development from the University of Sussex. He worked at the Central Bank and the Social Development Unit at the DNP before becoming an advisor to the Minister of Labor for Pension Reform. He also participated in the Health Proposals. After the reform he became Consejero Presidencial para la Política Social.

The National Planning Department lost much of its role in the health reform when Juan Luis Londoño and Nelcy Paredes left the institution for the Ministry of Health. Nevertheless, “Probably the “Misión Social” (Social Mission) from the National Planning Department was an important horizontal network: they gave us a lot of support with the information.”⁸⁰ (Interview, November 3, 1998). Their support was not continuous, but the change team asked them in many cases for particular information. They were also strategic, because they were developing the SISBEN, a tool that became the main mechanism for targeting social services and was used particularly in health for the subsidized regime. During the secondary law formulation the National Planning Department became an important actor again, mainly through Maria del Pilar Granados, who replaced Nelcy Paredes as the Health Division Director. She was appointed to that job with the recommendation of Juan Luis Londoño who had been in charge of selecting people for the Ministry.

During the formulation of the health reform proposal, Iván Jaramillo who had been advisor to the M-19 Health Ministers and had been part of the Hatogrande team that initially worked in the reform proposal, stayed with Juan Luis Londoño at the Ministry and participated in the discussions in Congress.⁸¹ He was an important member of the network because he had many assets the change team needed: knowledge of the health sector and knowledge of the decentralization process in health. He had also been a key actor during the formulation of Law 10, 1990 and he was working on the development of Law 60, 1993. Finally, his contacts with the AD-M19 were of strategic value from the political point of view.⁸² In addition, during the elaboration of the Hatogrande proposal he was a key person to propose alternatives that allowed for the moderation of the initial DNP and ISS proposals. Nevertheless, ideologically he was not identified with Juan Luis Londoño and after the Law was approved he continued to play an important role in the Ministry, but more in relationship to the development of Law 60 1993. “During the formulation of the secondary law, the main actors of the reform changed. Just those who agreed with Londoño’s ideas of the reform were there.” (Interview, July 27, 1998).

The team’s horizontal network also included people working in the Ministry of Health. This was also part of the strategy for institutionalization of the process within the MOH formal structure. The main horizontal network links within the Ministry of Health, were with Eduardo Alvarado, who became Deputy Minister, after Wolfgang Munar left that position. During the discussion of the Law in Congress, Alvarado, who had worked in health at the local level, was Alvaro Uribe Vélez’ assistant. He was very important in helping to gain the support of senator Uribe-Vélez for the change team.⁸³ Luis Gonzalo

⁸⁰ The “*Misión Social*” (Social Mission) is a project that Londoño promoted when he was Deputy Director at the National Planning Department with a high-level group dedicated to the technical, rather than bureaucratic aspects of social policy. At the time, it was directed by Tarcisio Castañeda a Colombian who earned a Ph.D. at the University of Chicago and had worked in Chile and in international organisations.

⁸¹ Ivan Jaramillo is an accountant from University de la Salle, México with an M.Sc. in Public Administration from the “Centro de Investigación y Docencia Económica”, México. Through his job he has specialized in administrative and financial topics related to health. He worked at the National Hospital Fund in the late eighties and was advisor to the Minister of Health during the promulgation of the Law 10, 1990. He was advisor to the M-19 during their period in charge of the Ministry of Health and then to Londoño. He has also been an international consultant and has worked for NGOs. Subsequently, he became a consultant and professor in health topics.

⁸² The Commission discussing the Law in Congress had representatives from that movement. In addition, when Juan Luis Londoño came to the MOH he found that institution colonized with a lot of people from that movement. They had been reincorporated into civil life and given these jobs, but in most cases they were not prepared to work in the tasks defined for them at the MOH.

⁸³ It seems that Gaviria appointed him Deputy Health Minister after the reform was approved, as a reward to Uribe-Vélez for his role during the reform. Moreover, it seems that Londoño suggested Alonso Gómez as deputy minister, as part of his strategy to consolidate his reform during the next government, but Gaviria did not accept that proposal (Interviews Aug 4/1998; May 19/1999).

Morales, the Deputy Minister assistant, also became very important at the end of the secondary law formulation process. He worked with Beatriz Londoño, a member of the change team, mainly in the definition of the Benefits Package procedures—“he was also driven by results and this fact made him very important” (Interview, November 12, 1998).

Horizontal ties were also built with people in senior positions at the Ministry such as Gonzalo Cano, who was in charge of the definition of the ESS and was a personal friend of Juan Luis Londoño; J.J. Arbeláez, who was the Public Health Director; and Juan Pablo Uribe, Promotion and Prevention Director and Deputy Health Minister during the Pastrana administration⁸⁴. In addition, there was a team of lawyers brought in by Oscar Emilio Guerra, the Health Superintendent and a member of the change team, who worked to support the health reform in legal matters. The most important ones were Chemás, Miranda, and Medina. Within the Ministry the change team also worked with Jorge Enrique Vargas, who was in charge of an IDB project to support the health decentralization process; José Vicente Casas, the General Secretary, who was in charge of the Ministry of Health reform; and Patricia Mejía, who was in charge of International Co-operation. The latter was very important because international co-operation was a strategic element in facilitating the work of the change team during the secondary law formulation process. Most of these individuals were young, highly trained, and with a lot of enthusiasm for the work and for the process of reform. They knew they had to work extremely hard even with the low salaries they were earning. But Londoño had managed to create a sense of mission and he upgraded the status of the bureaucracy in the Minister of Health (Interview, October 7, 1998). Most of them came with Londoño to senior positions within the Ministry, as part of his strategy for institutional reform.

POLICY NETWORKS ACROSS STATE-SOCIETY

The health reform process had different stages and the networks established by the team varied accordingly. During the Law formulation stage the main networks were with academics and international organizations; while for the Law debate and approval in Congress the most important actors were the Congressmen and in some cases their assistants. Later, during the secondary law formulation stage, private organizations with useful information and the necessary institutional experience for the development of the new health system were contacted. Finally, there was an attempt to build links with the incoming government. The change team had a fair amount of autonomy to decide with whom they made alliances, particularly during the formulation of secondary law, once the law was passed. But, as expected, there was pressure for more openness during the debate of the bill in Congress. But, as a result of the particular context of the health reform and because of decisions made by the change team, the process became more insulated after the formulation of the secondary law, in particular during the transition to the incoming government of President Samper.

When Juan Luis Londoño was appointed Health Minister and the change team was configured, he sought the support of researchers and academics from health foundations and NGOs who had been working on health reform proposals. The team thus got first-hand information and knowledge through what it saw as an informal training process. However, while these experts were constantly consulted for advice and information, they were not invited to join the change team or to participate in policy formulation and decision making. For instance, for drafting the bill, Londoño’s network included, among others, people from *Metrosalud* (Health Authority in Medellín, Antioquia) and FES Foundation of Leadership. The main actors involved were Antonio Yepes, who had been a member of the 1991 National Constituency Assembly, and Francisco José Yepes, respectively.

⁸⁴ It is important to point out that most of them come from Antioquia, the same region from which Juan Luis Londoño came.

During the debate of the bill in the Congress the team built important alliances with certain congressmen and their advisors. This was particularly true in the case of Alvaro Uribe Vélez, the Congressman in charge of presenting the bill at the Congress, who had also been in charge of the Labor Reform in 1990. Therefore, he already knew the people working on the social security reform, and was interested in the topic. Even though he is recognized as a Samperista, his ideology was similar to Gaviria's. He is also a politician who has tried to introduce into congress a renovating spirit based on ideology and policy proposals with national impact. He is also highly trained in relevant academic topics. Like Juan Luis Londoño, he had studied at Harvard and he came from Medellín, Antioquia.

Another important actor in congress was Victor Renán Barco, who had served in the senate for a long time. Even though he was considered an old-fashioned congressman, he was highly respected for his leadership and knowledge in economic legislation. He was in charge of Law 60 1993 in Congress, and was also an important ally. At other level, Eduardo Alvarado, Alvaro Uribe Vélez's assistant in Congress was an important link in the network. After the Law was approved Gaviria appointed him deputy health minister where, as seen in the previous section, he became an important member of their horizontal network for the change team.

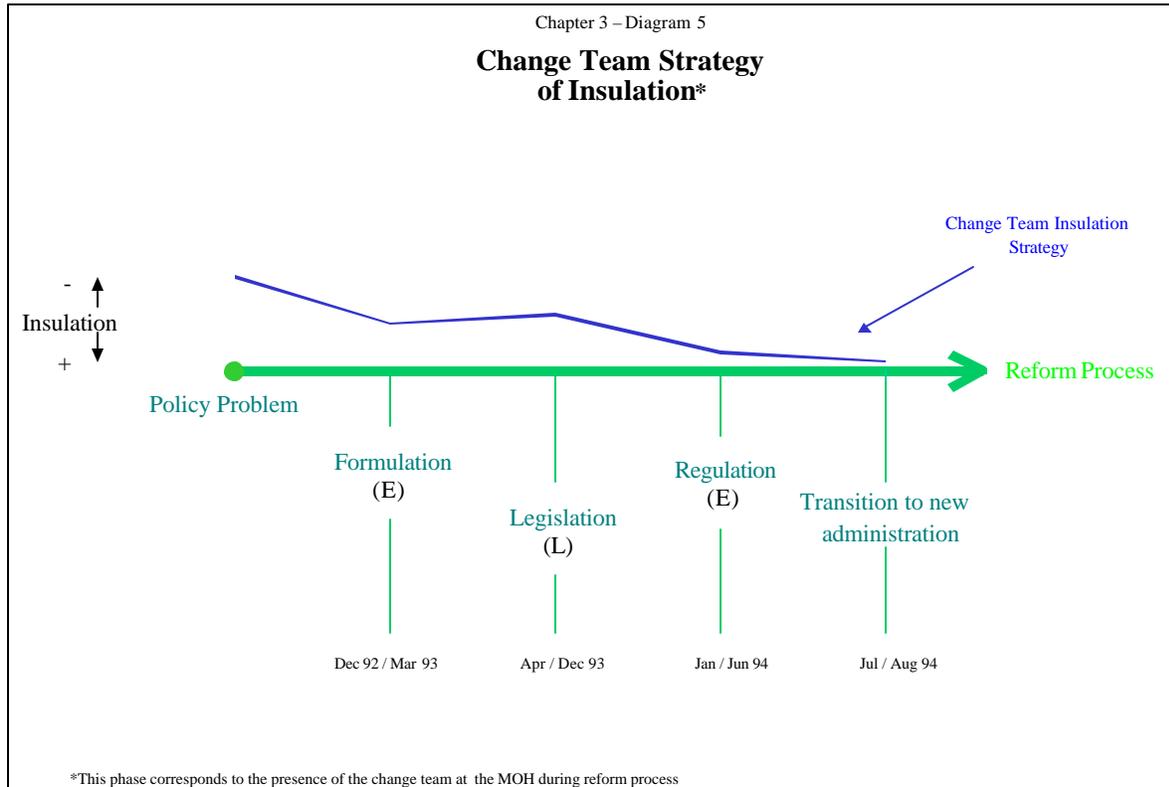
During the process in Congress other important network links were those established with FEDECAJAS, the confederation of "Cajas de Compensación Familiar." They represented a powerful interest group whose members manage the resources coming from a 4% tax on wages and have programs in different social sectors. Different governments have tried to reduce that tax, but Congress has not approved such a measure, due to the effective lobbying by the Co-operative Organizations. The government therefore has tried to stimulate the use of those resources according to their policies. To a certain extent this sector has become a source of funding for government policies, but the co-operative organizations have been able to retain control over the funds and to maintain the 4% tax. Besides being a powerful group, they had useful information for the change team, who wanted to use those institutions within the reform to take advantage not only of their resources, but also benefit from their institutional expertise. They were potential semi-private new actors in the reform that could play an important role both in the contributory and the subsidized regime.

During the secondary law formulation process, the team built networks with groups in both the State and society not so much for consolidating a group that would support the reform, but with the purpose of gathering information that was crucial for the development of the regulatory body for the new health system. Even when the formulation of secondary law was insulated and not many groups had access to influence the decisions taken at that stage; there was work to be done with certain institutions. Those institutions were important because they were useful in providing information needed for the formulation of secondary law in aspects such as health costs and tariffs. Most of the time, the change team opened and closed the doors to these groups and institutions according to its own agenda. Nevertheless it cannot be argued that it was a one way interaction, since those institutions also benefited from the intermittent proximity to the change team.⁸⁵

The team also included in its network, Augusto Galán, the brother of Luis Carlos Galán and a doctor, who was part of the Samper team in charge of the transition from the Gaviria to the Samper

⁸⁵ The *Cajas de Compensación Familiar* were very important during the process; less for their associations, as was the case during the discussions of the Law, but more for the experience and information they were able to share with the Government. The main ones were Colsubsidio (Cristina Arango and Miguel Pérez) and Cafam (René Orjuela, Planning Director). Of the paid-medicine companies, the more active ones were Colsanitas; SUSALUD (an insurance company from Antioquia— *indicato Antioqueño*, which after the approval of Law 100, 1993 developed EPS organisations)⁸⁵ and COOMEVA from the Valle region. (Interview, November 12, 1998). On the other hand, ACEMI was important particularly on the definition of complementary plans, and private companies were actors who put some pressure on the group decisions because they did not want a regulated market" (Interview, November 3, 1998).

administration. He expected to be appointed Minister of Health during the incoming administration. In addition, he had been President Gaviria's representative at the ISS board. "He was not in the day to day work, but he usually came to our Tuesday meetings." (Interview, November 12, 1998). He was the second Minister of Health during the Samper administration, where he was the key actor in halting the counter reform Alonso Gómez (the first minister of health during the Samper administration) was trying to push forward as described in chapter 2.



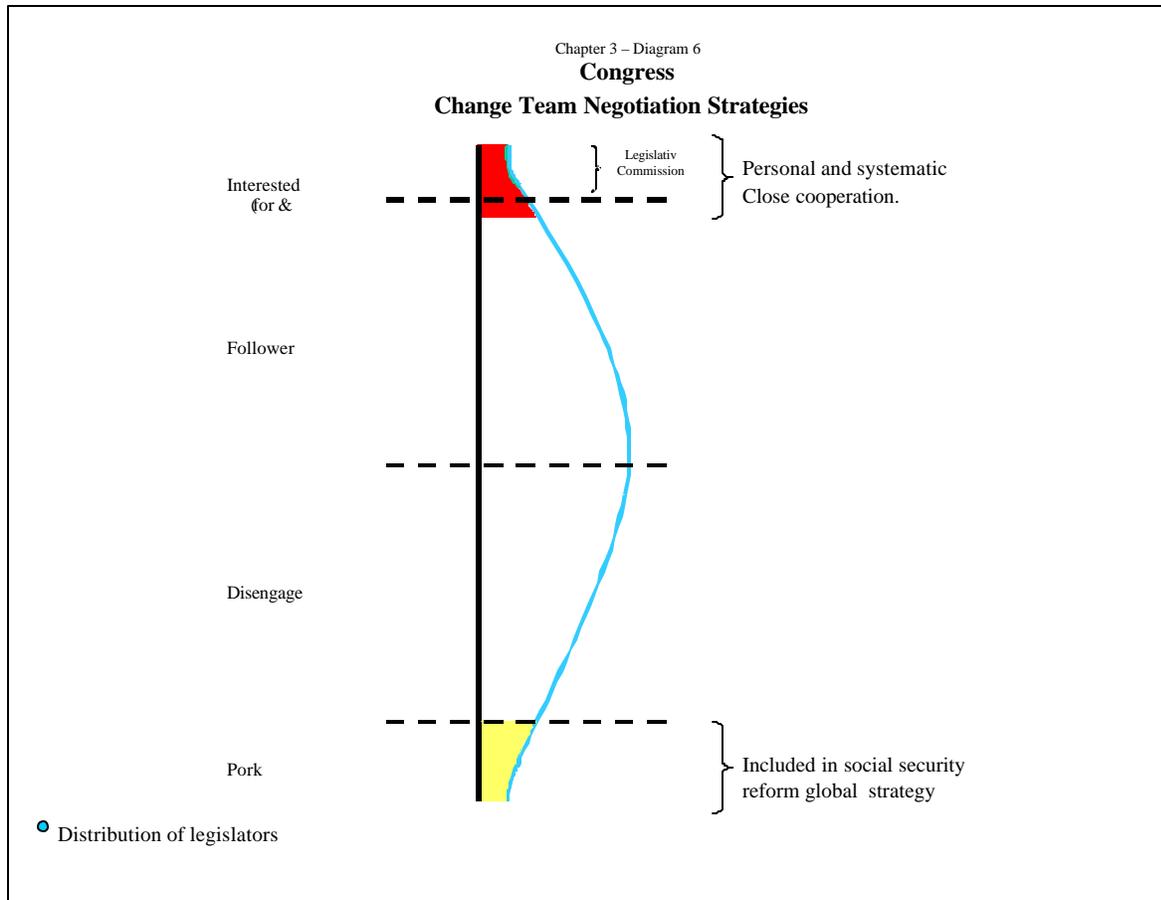
CHANGE TEAM POLICY STRATEGIES

As stated above, the creation and use of the health change team can usefully be considered a strategy in and of itself that allowed the State to have a greater margin to maneuver in preparing and brokering a highly complex reform proposal both with other governmental agencies and with interested groups in society. In turn, the change team used a series of strategies aimed at both securing its position of influence throughout the policy process and, as a result, enabling it to promote its reform agenda.

Those strategies changed according to the stage of the process. Usually they were not the result of a rational comprehensive process, rather they were developed on the day to day basis. Even when the change team used general strategies for the approval of the reform, it is also possible to distinguish particular strategies in each of the two main moments of the reform. The first stage during the process of legislation of the health reform in Congress was more open, by comparison with the second stage when the change team isolated itself again and had strict control over outside actors' access to the decision making process.

STRATEGIES USED DURING THE LEGISLATION PROCESS

One of the most important strategies during this stage was to develop the health reform formulation and discussion in Congress under the umbrella of a major social security reform project, where the pension reform received most of the attention. This strategy was reinforced with the decision by the health change team to behave as a technical group, leaving most of the political work of the reform in the hands of the Ministry of Labor that was in charge of the pension reform. In Congress, the health change team built a communication strategy with the senators, based as much as possible on numbers and diagrams, to convince them of the validity of their arguments (Interview, May 19, 1999).



In addition, the health change team decided to approach each individual senator involved in the discussion of the health reform, and listen to their suggestions, even when they were not always included in the proposals. For the Senators it was important to be heard during the discussions. The change team also relied on President Gaviria’s support to secure party votes for the reform. But they saw both strategies as necessary: to work with the senators one-by-one, while reinforcing this lobbying with attempts to gain the general support of the political parties.

The health change team also decided to work in close relation with a small number of senators they saw as critical for the outcome of the reform, both those in favor and those opposed to the reform. From the social affairs commission they worked mainly with Alvaro Uribe Vélez, the senator who presented the Law in Congress, but also with Maristela Sanín, Jaime Arias, María Cristina Ocampo (who was against the reform), and Corsi. As a result of this work, in some cases they were able to

advance the change team proposals in Congress, through the projects presented by those senators. On the other extreme the change team knew there was a group of senators used to clientelistic practices as their main negotiation strategy that had to be dealt with. However, they left most of this work to the Ministry of Labor that was in charge of the political strategy.

Nevertheless, before the approval of the reform, the Ministry of Health began the implementation of the ESS in the senators' regions. Many came to see in this component of the reform important political perspectives for their constituencies. This strategy strengthened the support some of them were beginning to provide for the reform.

Finally, the team decided to work closely with the group in charge of Law 60/1993 in Congress, because they saw the answer to the financial difficulties of the reform in that decentralization reform. With this objective in mind, they worked particularly with Senator Victor Renán Barco, an expert in Congress on economic matters.

During this stage, but also as a result of the Congressional request to debate the proposals with many groups, the change team talked to the visible head of all of the groups involved in the reform: unions, doctors, producer associations, pre-paid medicine organizations, academic forums, etc. This was more a process of gathering information than an arena for consensus building, because in general terms the change team did not change its proposal as a result of this long and exhaustive process of communication.

Moreover, several members of the team agreed that even when many people discussed the Law, the majority of them did not usually understand the implications it was going to have and the debate, even when open to many people, was primarily a formal process of consultation. This was due in part to the technical content of the proposal and the presentation of the project in a technical way that in some cases the politicians and other groups in society did not want to argue.

During the work at Congress, in addition to Londoño, Nelcy Paredes played a key role. "She went to Congress, she talked with every one and at very different levels from Congressmen to their assistants, explaining the proposals and acquiring knowledge about the reception by different congressmen and women. Later on Juan Luis Londoño, with the information that Nelcy gave him, went to Congress. He had credibility because he had belonged to the DNP." (Interview, October 7, 1998).

STRATEGIES USED DURING THE SECONDARY LAW FORMULATION

During the secondary law formulation process the team worked in isolation from outside influences, and even from the Ministry of Health's regular functions. "We worked in a team isolated from the Ministry. Because we did not have bureaucratic responsibilities we were able to deliver results and processes of change. We were driven mainly by results. The disadvantage is that a process that starts in that way is difficult to institutionalize, and when the team leaves nobody feels like taking it because it is far from every one." (Interview, November 12, 1998). "At the Ministry some people regarded us with admiration, others with deep preoccupation. They knew there were going to be radical changes and this fact was something that made people very suspicious." (Interview, November 12, 1998).

Although there was isolation from the outside, it is not clear if this was a decision taken on purpose or if this was related to the fact that there was no time. "There was no intended interest of excluding anyone from the process of discussion. During the formulation of the secondary law for instance the problem was related with the lack of time and the need to have results. When there was some consultation with external groups or persons, it was because they had good information, not because we needed to build consensus" (Interview, November 12, 1998).

During that stage the team developed several specific strategies. One of them was to seek international technical support. The best people working on health topics in the world came to Colombia as consultants for the reform. "I can name at least six top level people in health topics who came to Colombia several times to help with the reform: Philippe Musgrave, William Hsiao, José Luis Bobadilla, Julia Walsh, Robert Evans and Julio Frenk." (Interview, November 3, 1998). "The idea was that we discussed with them the secondary law proposals we had made and they gave comments about it." (Interview, November 3, 1998). "We went every where looking for the best people and the best experiences, and Juan Luis had great power to convince those people to participate. The international organizations and international co-operation were very important in helping us bringing those people to the process." (Interview, November 5, 1998). This group of international experts was there mainly to help the change team in defining the reform. It was a process of consultation only between international experts and the health change team members, even when during the final stage there was a seminar open to the public. At that moment this was a strategy to consolidate the future of the reform showing the international technical support for the project.

In addition, they also contracted loans for the health reform with the Inter-American Development Bank and the World Bank, as well as for the services of a consulting group from Harvard University, to prepare the master implementation plan, to monitor the performance, and to evaluate the effectiveness of the Health Reform. This strategy was seen as a mechanism to institutionalize the reform after the change of government. However, it is important to point out, that today members of the team believe this strategy did not have the expected results, because either there was not real compromise with the objectives of the reform by those institutions (at least since the perspective of the team) or there was not a clear understanding of the process (Interview, May 19, 1999)

Another strategy, which became more important during the formulation of secondary law though it had been present since the beginning, as a means of gaining legitimacy, was the use of technical expertise.⁸⁶ This was a strategy even when there were conflicts between the technical possibilities of the reform and the political decisions that had to be made. This strategy had many aspects: it gave the technical and thus apolitical aspect that the team wanted; it was an strategy of negotiation that they used with people that did not have the same level of training and recognized some legitimacy in this kind of knowledge. "I was asked to present the proposals to interest groups and congressmen who came to discuss the proposals," said one of the more technical members of the team. It was a strategy that facilitated the international support for the process, as well. Finally, it was also a strategy for exclusion. People who did not understand could not argue the main aspects of the reform. And Juan Luis Londoño did not face many technical arguments against the reform: probably the role played by Fedesarrollo was one of the few important ones in that sense. "Londoño only feared Fedesarrollo's arguments, he wanted to be sure the data were right when they had to discuss with him" (Interview, November 5, 1998).

To complement the strategies described here, it was important for the change to have mechanisms to be able to do studies and contract people as soon as they were needed and for the amount of money that was necessary. This was something that could not be done within the regular structure of the Ministry. For that reason the international co-operation became very important in supporting those kinds of efforts.

Juan Luis Londoño and his team were criticized because they were not doctors but economists deciding on health policies. Therefore Juan Luis Londoño decided to bring to the team doctors such as

⁸⁶ The group liked to talk based on numbers and graphs. They felt these instruments gave them technical legitimacy.

Beatriz Londoño and Teresa Tono. They gave him a better ability to communicate with doctors (Interview, October 7, 1998).

As a continuation of the strategy developed during the legislation process, the health change team was also involved in the development of the Law 60, 1993, that was a crucial point in defining the new resources for the reform, particularly for the subsidized regime. Londoño appointed Jaramillo and González, two persons close to his team, to work on those topics. This gave them an important control over the development of that reform, and some people argue that this helps to explain the importance of health in that strategy in comparison with other social sectors such as education.

Another strategy during the secondary law formulation, particularly at the end of Gaviria's government, was to try to convince the people who came with the new government of the benefits of the reform. In 1994, people from both presidential campaigns, Samper's and Pastrana's, were invited to different technical meetings with international experts on the topic of the health reform. However, most of the transition process with the Samper team was done through Augusto Galán, who in the end was not appointed as the first health minister of the Samper administration.⁸⁷ This fact hindered the institutionalization of the reform in the terms proposed by the health change team. In addition, even when Londoño and his team had some discussions with the new team to be in government, it was less a matter of creating consensus around the secondary law formulation, but more to give them general information about the process. At the end, the team was as isolated as possible and the process became very difficult.

Summing up, there was a moment when the change team wanted to convince the people who would be in power after them and they tried to communicate the reform as a strategy for its viability. However they always retained the power over what could be shared and what could not. This situation always generated conflict. In addition, at the end of the secondary law formulation process, and probably due to its speed, the team became isolated also from other institutions within the government that wanted to be part of the process such as the DNP and the Presidential Office for Social Development.

Finally, to try to institutionalize the reform, Juan Luis Londoño asked some of the change team members, particularly Nelcy Paredes and Beatriz Londoño, to stay after he left office and to be advisors to the new Minister. However with the arrival of the new government, the team as such ended, and even more important, their direct support from the Minister, the President, and the economic team disappeared. With the exception of most of the Gómez period, Paredes stayed at the Ministry until 1998. Beatriz Londoño left soon after because of problems with Gómez and she became the Health secretary for Bogotá where she replicated the change team strategy and began the institutionalization of the process. Because of the local autonomy districts have under the decentralization policy, she was able to start the reform even without the support of Alonso Gómez as Health Minister.

As Bogotá's Health secretary, she was able to further the reform process at the local level. Budgetary resource allocations for health increased 4.5 times between 1990 and 1996 (without considering resources stemming from FOSYGA nor from the Cajas de Compensación), and the district resource allocations for health were also doubled. Public hospitals were able to increase their revenues from contracts by 8.8 times. The district adopted a primary health care program that was to be replicated by the Ministry of Health for other regions. Inter-institutional relations were strengthened, resulting in health and sanitation control programs that freed hospital funds and efforts previously assigned to these responsibilities. There was also significant progress made in the process of decentralization and greater hospital autonomy: Hospital boards were organized with the participation

⁸⁷ Londoño was given signals that Galán was going to be appointed Health Minister if Samper was President, and he worked hard to convince him of the benefits of the reform.

of consumers, and a system of civil service (or administrative career) was also put in practice within them. However, the formal conversion of these public hospitals into State Social Enterprises was blocked in local Congress at the instance of unions. Finally, one of the most visible results of the reform in Bogotá was the fast registration and incorporation of the poorest to social security, the creation of 19 ESSs, and the creation of the territorial council for the health component of social security.

GENERAL STRATEGIES TOWARDS THE REFORM

In addition to the particular strategies used during the legislation and secondary law formulation process, the change team developed others that were more general. The most important one, as stated previously, was that the health reform was part of a comprehensive package of social security reform. This condition facilitated the political discussions in Congress during the formulation stages. However there were other decisions that were equally important.

During the whole process, but particularly before and during the legislation, the team tried to have contact with every visible figure affected by or interested in the health reform. This was an important strategy, but it was not a consensus-building strategy as such. They listened to many people and many groups, and they learned from some of them, but they did not intend to develop a proposal with them. Having said that, it is also important to point out that the team was able to develop a health reform project that was politically feasible, being aware of the tensions around the reform between those in favor of a Chilean model and those defending the role of the State. To a certain extent they were able to develop a proposal in the center, with solidarity mechanisms and instruments to try to avoid segmentation. Nevertheless, groups in favor of the state monopoly and against competition, still saw them as a neo-liberal team.

The change team decided, that in order to pass the law through Congress, it was necessary to make it as general as possible, to diminish negotiation. This strategy, that proved useful during the legislation, left important room to maneuver during the secondary law formulation stage. The change team took advantage of that condition, defining broad aspects of the law reform by decree. However, the same space has been open for other governments in charge of developing the implementation, and they have used it according to their own principles that, particularly at the beginning of the Samper administration, were contrary to those of the original change team.

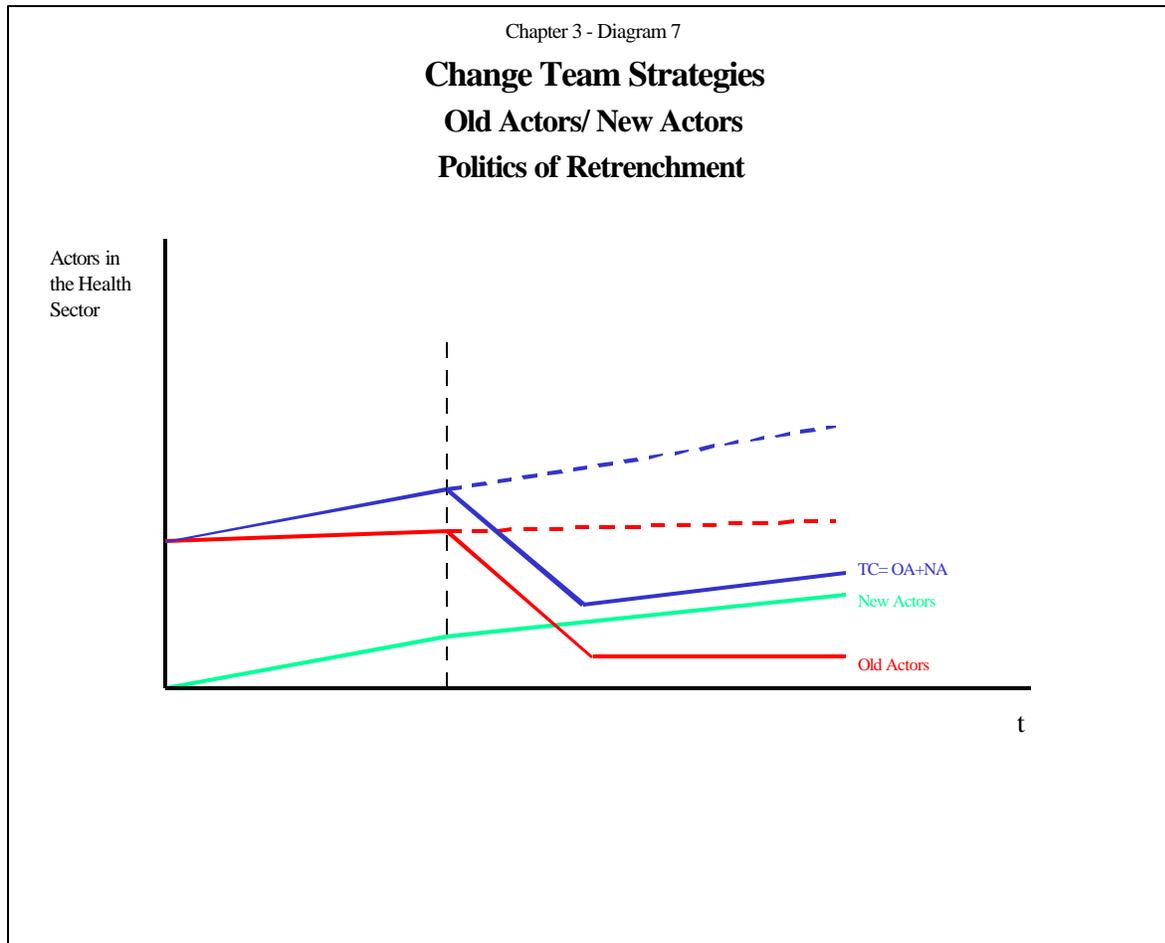
The change team also decided that the best strategy to reform the health sector was through the definition of new actors and resources within the system; not with the radical transformation of the old actors of the system such as the ISS. The new actors and resources were expected to stimulate the transformation of the old actors and resources in a relatively short period of time. This is the reason why the health change team chose to give priority to the development of the new components of the system during the development of the reform, rather than the establishment of clearer guide lines for the implementation of the reform and the transformation of the old system. This decision, even when it generated significant new resources and interest groups who have been instrumental in achieving the results of the reform, has not had the expected results. The old actors have not been modified as expected and as described in the annex "Policy Tracer" of this work, most of the important results of the reform are explained by the dynamic of the new actors and institutions within the system. This process of slow transformation, has also been the source of increasing costs in the sector.

Another strategy used by them, was based on a phrase Juan Luis Londoño used often: "the best is the enemy of the good."⁸⁸ The team was eager to take risks in spite of their their costs because trial

⁸⁸ Which could be interpreted as the saying "go for broke."

and error or pilot experiences were not considered a possibility. They thought that in making Political decisions, the optimum was not always possible. And this is reflected for instance in the fact that some people underestimated the complexity of the reform and its technical demands, while others, like Juan Luis Londoño, understood them but thought it was important to try to go as far as possible with the reform to guarantee the reform survival. (Interview, October 7, 1998). This decision can be explained by the lack of time to do something incremental, but also because there was a conviction that in order to have any effect on health policy, it was necessary to go as far as possible with the proposal.

Londoño made important efforts to institutionalize the reform within the Ministry of Health. In



December 1992 as a result of a more encompassing program of institutional reform within the state, the Ministry and the Superintendence were reformed. Juan Luis Londoño seized the opportunity and changed most of the directors at the Ministry of Health, appointing people who believed in the reform. They were young, highly trained, and believed in change. Even when they were not directly involved with the health reform as such, they were key actors in trying to put the reform in practice. This strategy proved to be important because some of them stayed at the Ministry after the change of government and others who left, still played key roles in the health sector, working now in Foundations, NGOs, or health policy at the local level.

Those decisions were complemented with an impressive communication campaign, through T.V, radio, and other mass media. However, the communication strategy did not focus on the reform itself, but in public health actions with important impact such as AIDS or promotion and prevention. They

decided to spend a significant amount of money in this campaign, a strategy that was the responsibility of one of the members of the change team. This strategy proved to be important, as it put health matters on the public agenda.

It also has to be said that during the whole process the team was aware that the most important resistance to the reform could come from within the Executive – very much as a result of the initial policy debates on social security reform. Other groups in the Executive had very different reform projects – notably the groups around the ISS. Thus, the change team sought to neutralize these groups by using an insulating strategy that avoided discussion and open participation, while seeking to minimize their influence.

The use of those different strategies is an evidence of the important room the change team had for maneuver within this particular context. Those strategies explain to an important extent, both the content of the reform and some of the implementation achievements and obstacles.

CONCLUSIONS

The use of a change team was one strategy used with success in the case of the health reform in Colombia. This change team was able to achieve results because of the particular strategies they used, but also because their work was part of a larger state reform and was related to a team that was dealing with the economic reforms. Nevertheless, the use of this strategy has had mixed results in dealing with the implementation process.

There were several key aspects developed by the team. They were able to develop a proposal that had political feasibility, combining elements from the extreme positions around the reform, and making it possible to have a reform formulated and approved by Congress. As a result, the proposal had both elements of solidarity and competition. On the other hand, they took advantage of the particular context in which the health reform was developed. Two main facts exemplified that. First, it was the Congress that asked for a comprehensive health reform; but once the Executive saw it as an imperative, they were able to use the health change team to regain leadership of the reform. They also went further than the Congress expected. Second, the health change team had the ability to participate in the development of Law 60/1993, and through that strategy they came up with solutions to many of the financial difficulties raised by the reform, particularly for the subsidized regime. Therefore, within the limits of a particular context, the health change team was able to take decisions that were crucial for the reform.

The group's legitimacy came from their academic training and their work. The team was a small group, most of them highly trained and with an international background. For the group the technical work was the most important one, even when at the end their decisions were also political. But they saw themselves as apolitical. For most of them the main objective and motivation was professional one but not necessarily within government. Moreover, their expertise was not only in health or economics, but also in communications, law, and public administration.

Their ideology was that of the early nineties—in favor of modernization by changing the role of the state in the social sectors; promoting the role of the private sector; increasing efficiency; and using different mechanism for delivering social services such as targeting and demand subsidies. The social sector was seen mainly as an important component of human capital and in that sense a necessary condition for economic development.

Their work was isolated, and they were not part of the formal structure of the Ministry of Health. Nevertheless, the strategy of isolation and speed, particularly in the process of decree development,

even when favorable for the approval and normative development of the reform, was not useful during the stage of reform implementation, where other political and social actors who were left outside the process, came to play an important role in delaying or changing the nature of the reform as discussed in the Policy Tracer Annex.

The team did not have political support from any specific group within or outside the State. This fact gave them independence, but also vulnerability. The team existed during the time they had the support of the President himself and of the economic team within the government. In addition to those vertical networks, they had to establish horizontal and across society networks, to achieve their goals.

The team's composition, networks, and strategies changed according to the stage of the reform. During the stage of formulation and legislation they had contact with many different groups involved in the reform. However, during the secondary law formulation process they became very isolated. This isolation was, in part, the result of the lack of time, but also of a strategy for retaining control over the reform. Even though this strategy enabled them to develop a significant volume of decrees and to establish the basis for the development of the new actors of the reform, it was also a source of many conflicts at the beginning of the implementation process (that was the responsibility of another team).

The health change team took two crucial decisions during the reform that have had mixed results during the implementation process. First, they decided to go for a Law with general principles that could subsequently be further developed by the Executive. This strategy made gaining approval for the Law less difficult and provided enormous flexibility during the process in which the health change team promulgated its decree. Nevertheless, this space has also been used against the principles of the change team reformers by the following administrations that have had the same room for maneuver. Secondly, they decided to give priority to the development of the new actors within the system, instead of the direct transformation of the old ones because the latter was very difficult in political terms. The change team thought that new actors and resources would stimulate the transformation of the old ones; however, the results of this strategy have not been as expected. Even when in the short term it was a successful strategy to secure the approval of the reform by Law, in the longer term the old actors and the old resources have not been transformed as expected.

The team tried to institutionalize their work through different strategies. The legal strategy was very important and was materialized in the approval of the Law 100 and its regulatory package development. They also attempted to change the people as well as the structure of the Ministry of Health and to establishing network links between the team and the people working there. They tried to convince the group that was going to replace them in power of the benefits of the reform and leaving some of its members within the new team. These actions were complemented with the approval of loans with the World Bank and the IDB and with an international network in favor of the reform that included the best people working in health at the time.

It remains to be seen, however, if these decisions will prove sustainable and provide long-term benefits during the implementation process, which is still ongoing.

ANNEX I. POLICY TRACER: REFORM IMPLEMENTATION (1995-97)

INTRODUCTION

This research has described the process of health reform in Colombia during the nineties, which has been one of the most radical reforms in social policy in the country and the most important one in health during the last decades. The context of the reform was described: it was developed in a moment of State reform and was accompanied by political changes, particularly during the ANC. Thus, this was a context of significant change, but not one of profound crisis in the health sector.

A key role was played by a change team that—within limits—was able to maneuver and define to a certain extent the content of the reform. This team was mainly a technocratic one, and worked at the Ministry of Health. However, at the same time it managed to build support from the President and the economic team in government and it was able to be relatively isolated from interest groups.

The principles of the reform were defined in the 1991 Constitution and the reform was developed in Law 100, 1993 and the Executive decrees that followed. However its implementation began in 1995, under a different Government than the one that was in charge of the definition of the problem and formulation of the reform. It is the implementation that can indicate how far the reform has gone in practice. This is the precise goal of this annex: to evaluate the reform, in terms of its objectives.

According to the national Constitution, the main principles of the reform are universality, solidarity, and efficiency. Law 100 added the following characteristics: equity; compulsory affiliation with social security; integrated health services (promotion, prevention, diagnosis, treatment, and rehabilitation); free choice of EPS and IPS; autonomy of health institutions; administrative decentralization; participation; and consensus building through national and regional councils in social security; and improvements in quality. Therefore, it is in relationship with the three main principles of the reform and its strategies of compulsory affiliation to social security, equity, and regulated competition, that the evaluation of the implementation process will be done in this annex.

This evaluation, for each of the three objectives, describes the main results for the two regimes of the new system: the contributory regime and the subsidized regime. Each has had a different outcome, and each seems to answer to a different logic and incentives. The subsidized regime is the most important one in terms of social policy, for its impact on reducing poverty and inequity. It is the regime defined for the poor. However, it has more difficulties because its operation within the reform implies greater transformations of old actors than is the case with the contributory regime.

Although the Law was approved in December 1993, implementation only began in 1995, as established by the Law. The evaluation covers the period 1995⁸⁹ to 1997⁹⁰. Because the reform is recent and there is not enough information available, this evaluation is preliminary and covers a reform process that is not yet consolidated. Nevertheless, there are clear trends that can be analyzed. The main sources of information for this evaluation were primary and secondary ones, available from public institutions and technical analysts.

Even when there have been significant transformations as a result of the reform, the process of implementation has been more difficult than expected. This has resulted from the complex design, probably because of insufficient attention to the implementation process during the definition of the

⁸⁹ The implementation process started in 1995 as established by the Law 100, 1993. The prior year, 1994, was a period of preparation for the changes to come.

⁹⁰ Data for 1998 were not available at the time this report was written.

reform process. There has also been resistance both outside and inside government toward the changes. In spite of many difficulties, there are also signs of important progress such as increases in coverage, resources, and institutional development.

To describe the main results of the reform, this annex is organized as follows. First, it describes the results of the reform in terms of affiliation to the health social security system. This is followed by a description of the important institutional changes and an account the amount and use of the new resources allocated to health. This description is done for both the subsidized and the contributory regime. The analysis then focuses on the main obstacles of the reform, which can be understood as the result of an incomplete process of transition. This situation is reflected mainly in the lack of transformation of supply subsidies into demand subsidies; the difficulties for public hospitals to change; the resistance of health workers towards the reform and also the problems of information, regulation, and administration. Then there is an assessment of the reform in terms of its main principles which are universal coverage, efficiency, and solidarity, bearing in mind other principles introduced by the Law such as integrity of care, quality and regulated competition. Finally, there are some concluding remarks.

MAIN RESULTS OF THE REFORM

AFFILIATION WITH SOCIAL SECURITY FOR HEALTH

Compulsory affiliation with social security is the main strategy of the reform to increase coverage. The stated goal is to make it universal by the year 2001.⁹¹ It is precisely in this area where the main achievements of the reform have taken place.

Affiliation with the health component of the social security system has increased dramatically after the reform. While in 1993, 20.6% of the total population was affiliated with social security, by December 1997 affiliation was almost three times as much: 22 million people were covered, which represented 53% of the population. Of the total number of affiliates, 14,901,303 belonged to the contributory regime (68%) and 7,026,690 to the subsidized regime (32%). For the latter, that represents 47% of the poor. Without doubt, this has been a positive result of the reform.

ANNEX I - DIAGRAM 1

HEALTH COMPONENT OF SOCIAL SECURITY COVERAGE		
YEAR	% OF TOTAL POPULATION	RATE OF GROWTH
1991	20.6%	
1993	26.8%	30.1%
1997	53.0%	97.8%

Source: Fedesarrollo, based on Ministry Of Health

⁹¹ Law 100, 1993

ANNEX I – DIAGRAM 2
AFFILIATION WITH SOCIAL SECURITY IN HEALTH 1997
DEPARTMENTAL DISTRIBUTION

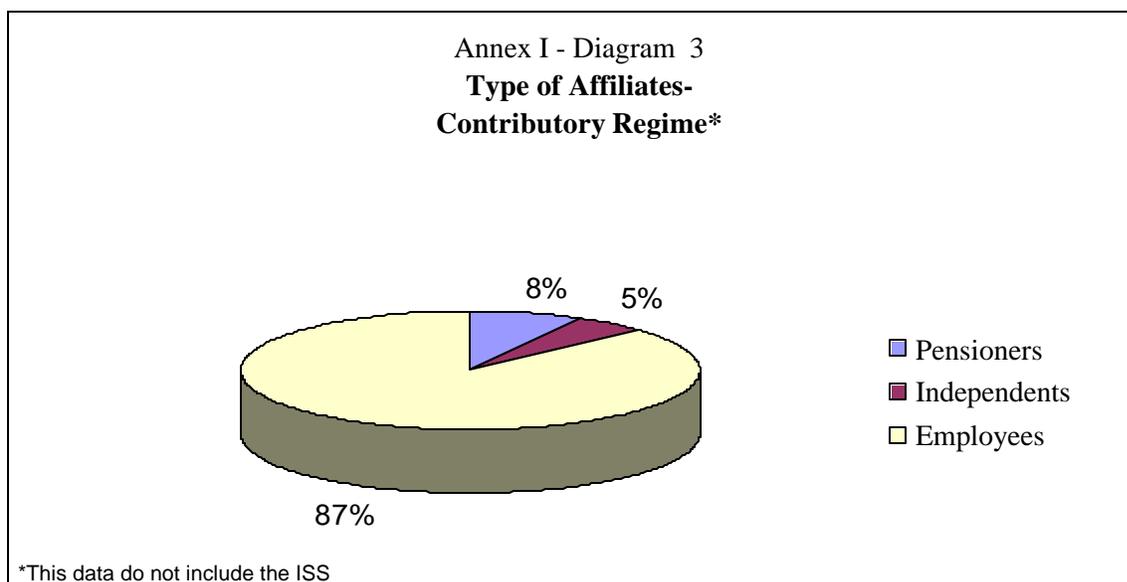
DEPARTMENT	CONTRIBUTIVE REGIME AFFILIATES	SUBSIDIZED REGIME			TOTAL AFFILIATION	TOTAL POPULATION	COVERAGE OF TOTAL POPULATION
		AFFILIATES	POPULATION WITH NBI(1)	COVERAGE OF POPULATION WITH NBI(2)			
AMAZONAS	8,449	10,217	10,718	95.3%	18,666	60,251	31.0%
ANTIOQUIA	2,618,847	1,014,787	1,640,098	61.9%	3,633,634	5,243,906	69.3%
ARAUCA	25,592	31,949	108,447	29.5%	57,541	206,151	27.9%
ATLÁNTICO	774,866	220,888	627,686	35.2%	995,754	1,984,910	50.2%
SANTAFÉ DE BOGOTÁ	4,050,768	910,474	1,044,832	87.1%	4,961,242	6,004,782	82.6%
BOLÍVAR	196,539	290,636	1,274,688	22.8%	487,175	1,843,630	26.4%
BOYACÁ	234,693	385,650	523,490	73.7%	620,343	1,351,829	45.9%
CALDAS	321,025	144,798	292,688	49.5%	465,823	1,084,081	43.0%
CAQUETÁ	72,629	58,701	232,184	25.3%	131,330	396,537	33.1%
CASANARE	57,466	80,886	116,038	69.7%	138,352	226,896	61.0%
CAUCA	221,098	275,878	611,614	45.1%	496,976	1,197,874	41.5%
CESAR	110,753	220,853	482,227	45.8%	331,606	873,044	38.0%
CHOCÓ	29,118	93,094	332,898	28.0%	122,212	409,599	29.8%
CÓRDOBA	163,084	160,019	889,849	18.0%	323,103	1,353,922	23.9%
CUNDINAMARCA	584,510	464,637	690,745	67.3%	1,049,147	1,975,564	53.1%
GUAINÍA	971	3,311			4,282	31,148	13.7%
GUAJIRA	62,475	89,269	255,240	35.0%	151,744	459,326	33.0%
GUAVIARE	4,701	12,911	52,276	24.7%	17,612	110,631	15.9%
HUILA	216,895	231,531	359,164	64.5%	448,426	894,109	50.2%
MAGDALENA	203,753	140,773	712,826	19.7%	344,526	1,218,836	28.3%
META	253,650	84,260	267,983	31.4%	337,910	659,825	51.2%
NARIÑO	162,175	391,944	833,003	47.1%	554,119	1,558,045	35.6%
NORTE DE SANTANDER	276,438	222,845	524,554	42.5%	499,283	1,252,867	39.9%
PUTUMAYO	16,172	89,492	88,672	100.9%	105,664	273,981	38.6%
QUINDÍO	185,372	69,745	127,419	54.7%	255,117	535,711	47.6%
RISARALDA	447,328	92,738	241,447	38.4%	540,066	905,780	59.6%
SAN ANDRÉS	26,280	10,543	21,925	48.1%	36,823	65,700	56.0%
SANTANDER	743,095	415,450	601,843	69.0%	1,158,545	1,911,830	60.6%
SUCRE	90,434	136,432	482,901	28.3%	226,866	749,152	30.3%
TOLIMA	286,401	202,607	500,944	40.4%	489,008	1,310,963	37.3%
VALLE	2,042,461	452,571	978,361	46.3%	2,495,032	3,970,302	62.8%
VAUPÉS	2,078	1,333			3,411	26,865	12.7%
VICHADA		15,468	11,709	132.1%	15,468	66,676	23.2%
TOTAL	14,490,116	7,026,690	14,938,469	47.0%	21,516,806	40,214,723	53.5%

Source: Based Cuartas (1998) and Fedesarrollo (1998)

Notes: (1) Population with unsatisfied basic needs (poverty measure).

(2) It supposes adequated targeting.

In spite of those important results, the goal of universal affiliation by the year 2001 will not be met. In the case of the contributory regime, for instance, the reform has been able to expand the affiliation primarily as a result of the introduction of the family coverage: 53.1% of the people covered by the contributory regime were family members of the affiliates who were covered previously. Therefore, even when the expansion in coverage has been significant, in many cases those benefits have gone to additional members of the same families, rather than new families. In addition, the reform has failed to incorporate the self-employed into the system, in spite of having established compulsory affiliation by Law. From the total of affiliates incorporated into the contributory regime, 87% were dependent workers, 8% pensioners, and only 5% were independent workers (Ministerio de Salud, 1988).⁹² This demonstrates the difficulty of incorporating new groups into the system.



Another solid achievement of the reform has been its territorial expansion, primarily in the case of the subsidized regime. Before the reform, social security in health was limited to the main cities, with low or non-existing coverage in remote and rural areas. Currently, there is coverage in every territorial entity, particularly within the subsidized regime, as a result of the co-funding policy, that in 1997 invested resources in almost every one of the 1,050 localities of the country. In spite of this important progress, there is still concentration in the health social security system: 62% of the social security affiliates are in the more developed regions: Antioquia, Atlántico, Cundinamarca, Santander, Valle, Bogotá, where only 52.4% of the population lives. The system is particularly concentrated in large urban areas where economies of scale are important, affiliation efforts are more profitable, and it is easier to establish health provider networks for the users. The problem of concentration is particularly true for the contributory regime that has 74% of its affiliates in the more developed areas (Cuartas, 1998).

In spite of the achievements in coverage, the system is vulnerable to the economic performance of the country. As a result of the recent crisis on production and employment, affiliation with the contributory regime decreased 25% between January and June 1998. This situation also affects the subsidized regime, because the solidarity account is partially funded with a percentage of the resources of the contributory regime.

⁹² This does not take into consideration the ISS.

INSTITUTIONAL CHANGE

As a result of the reform there are now new institutions with different interests within the health sector. Those are basically the EPS in the contributory regime and the ARS in the subsidized regime. In addition, the existing actors within the sector before Law 100, 1993 have been transformed and the power relationships have been modified. These changes have affected the reform implementation process.

Contributory Regime

EPS

Without doubt, another important result of the reform has been the dynamic of the EPS that in part are responsible for the increase in affiliation within the contributory regime. In 1998 there were 30 EPS in this regime: 10 of them public, 1 mixed, 4 CCF⁹³ and 15 private. However, with the exception of the ISS that covers 63% of the contributory regime, and in spite of their important growth since 1995, none of them covers more than 6% of the total of enrollees. Therefore, even when the private EPS have had an important growth in their affiliation that currently represents 4.5 million people, the contributory regime is still in public hands.⁹⁴

Therefore, within the contributory regime the ISS is the main EPS. However as discussed in the next section, it has faced enormous difficulties as a result of the reform. Even though the Institute lost its monopoly on social security affiliation, and in spite of the fact that more than 30 EPS have been created to manage the contributory regime, the ISS still has 63% of the affiliation in this regime and it is the most important public institution in health. However, this institution has not changed according to the intentions of reform and it has had problems that can affect the whole system.

⁹³ They have origin in para-fiscal resources, but work like private institutions.

⁹⁴ Besides the ISS and the other EPS, within the contributory regime there are 30 “adapted institution” which cover 5% of the affiliates. They correspond to social security institutions for public workers that were operating before the reform. According to the Law 100, they have to be transformed, cannot expand coverage and will survive only while they attend the workers that were previously affiliated with them.

Annex I - Diagram 4

CONTRIBUTORY REGIME: AFFILIATES BY E.P.S.							
E.P.S	Type of E.P.S.	1995		1996		1997	
		Number	Participation	Number	Participation	Number	Participation
I.S.S.	PUBLIC	7,330,080	86.79%	10,919,873	75.71%	9,255,287	62.11%
RISARALDA	PUBLIC	569	0.01%	10,462	0.07%	6,404	0.04%
CAPRECOM	PUBLIC	-	-	-	-	243,376	1.63%
CORPORANOMIMAS *	PUBLIC	-	-	2,475	0.02%	2,703	0.02%
COMVIDA	PUBLIC	31,220	0.37%	41,559	0.29%	47,587	0.32%
CAJANAL	PUBLIC	-	-	-	-	543,950	3.65%
CAPRESOCA	PUBLIC	-	-	8,475	0.06%	12,054	0.08%
BARRANQUILLA SANA	PUBLIC	-	-	-	-	12,808	0.09%
CALI SALUD	PUBLIC	-	-	-	-	746	0.01%
I.P.S. DE CALDAS	PUBLIC	-	-	-	-	581	0.00%
SELVASALUD	PUBLIC	-	-	-	-	-	-
TOTAL PUBLIC EPS		7,361,869	87.16%	10,982,844	76.15%	10,125,496	67.95%
COLMENA	PRIVATE	220,669	2.61%	345,707	2.40%	271,026	1.82%
SALUD TOTAL	PRIVATE	29,244	0.35%	333,814	2.31%	433,821	2.91%
CAFESALUD	PRIVATE	73,875	0.87%	218,169	1.51%	253,273	1.70%
BONSALUD*	PRIVATE	117,780	1.39%	121,174	0.84%	41,628	0.28%
SANITAS	PRIVATE	69,186	0.82%	107,724	0.75%	118,714	0.80%
UNIMEC	PRIVATE	89,932	1.06%	303,112	2.10%	425,923	2.86%
COMPENSAR	PRIVATE	62,249	0.74%	154,205	1.07%	206,079	1.38%
COMFENALCO	PRIVATE	17,500	0.21%	39,429	0.27%	61,988	0.42%
ANTIOQUIA							
SUSALUD	PRIVATE	199,701	2.36%	326,092	2.26%	435,859	2.92%
COLSEGUROS	PRIVATE	9,098	0.11%	78,071	0.54%	92,395	0.62%
COMPENALCO VALLE	PRIVATE	11,676	0.14%	58,792	0.41%	118,555	0.80%
SALUDCOOP	PRIVATE	63,588	0.75%	517,328	3.59%	858,394	5.76%
HUMANA	PRIVATE	5,821	0.07%	28,548	0.20%	53,731	0.36%
COLPATRIA	PRIVATE	7,814	0.09%	28,288	0.20%	38,247	0.26%
COOMEVA	PRIVATE	16,180	0.19%	199,235	1.38%	202,272	1.36%
FAMISANAR	PRIVATE	86,588	1.03%	332,079	2.30%	402,105	2.70%
S.O.S.	PRIVATE	3,230	0.04%	138,432	0.96%	175,089	1.17%
CRUZBLANCA	PRIVATE	-	-	105,114	0.73%	233,152	1.56%
SOLSALUD	PRIVATE	-	-	5,290	0.04%	10,174	0.07%
METROPOLITANA DE SALUD	PRIVATE	-	-	-	-	-	-
TOTAL PRIVATE EPS		1,084,131	12.84%	3,440,603	23.85%	4,432,425	29.75%
CÓNDOR	MIXED	-	-	-	-	643	0.00%
ADJUSTED ENTITIES**		-	-	-	-	342,739	2.30%
TOTAL		8,446,000	100.00%	14,423,447	100.00%	14,901,303	100.00%

Source: Cuartas (1998) and Ministerio de Salud (1998)

* In process of liquidation

Notes: ** Entities which cannot increase coverage beyond their current number of affiliates.

The ISS

As a result of the reform, the institution was due to have an administrative change aimed at improving its role within the new system. With this aim, it was converted into an industrial and commercial state enterprise with autonomy and contracting rules according to the ones that private firms have. This was done to allow the institute to compete with private EPS. On the other hand, it was authorized to become an EPS with national coverage, but with decentralized services and autonomy for its health provider institutions.

Even when the affiliation and the amount of resources for the ISS had increased dramatically after the law, primarily as a result of the expansion of family coverage and the increase in the payments from the contributory regime which rose from 6% to 12% of the family income, the Institute did not change as expected. Through 1998 there had been no separation between the administration of the affiliation and the provision of services, which was one of the conditions of the Law to promote efficiency. On the other hand the Benefits Package offered by the ISS contained procedures and interventions that were not covered by the other EPS. This constituted both an unfair competition strategy with the other EPS and increased costs for the Institute.

Until the end of 1997 the ISS was reluctant to enter in the compensation process established for the contributory regime.⁹⁵ Recently it seems that it is trying to enter, but reporting deficit levels that can not be covered by the compensation account. The Institute has important financial difficulties. In 1997, the UPC was established as \$207.362, but the average cost of attending a person in the Institute was \$232.091. In addition, until 1998, the ISS refused to introduce co-payment and “moderating quotas” as established by the Law. All of these practices constituted unfair competition (probably the ISS wanted to retain its contributors), but also have contributed to the financial difficulties of the organization (Cuartas, 1998).

Another issue that has an important impact on the ISS’s financial problem is the weight of the overhead costs, which are 26% of the total (the new system expects 15% as the maximum). This is explained mainly by the pay-roll costs of the institute, which are overburdened with the salary benefits of its employees that are more generous than those stated by law for the average worker⁹⁶(Cuartas, 1998).

The transformation of the institution has been also hindered by political actors, mainly unions, and problems of political interference basically at regional levels. Therefore, even when it is supposed to behave as a private enterprise, it can not compete under the same conditions.

It is important to point out that there has not been massive disaffiliation from the ISS, but on the contrary, there has been loyalty by its affiliates.⁹⁷ Moreover, aside from the inefficiencies it already had, many of the problems of the institution are explained by its tremendous growth in terms of affiliates (particularly as a result of the extension of family coverage), which grew from 7.3 million enrollees in 1995, to 9.3 million in 1997. The ISS has advantages like its extensive geographical coverage and reliable services in secondary and tertiary levels of attention. In addition, it has maintained conditions outside the law which have implied both unfair competition but also created financial difficulties for the institution. The increases in coverage might well be a result of the broader package of services

⁹⁵ Every EPS collects the payroll taxes from their affiliates. If the UPC corresponding to those affiliates is higher than its UPC, the EPS has to transfer those resources to the FOSYGA. If it is lower, the FOSYGA, from the compensation account, will fund the difference.

⁹⁶ The ISS workers get pensions, which are equal to 100% of the salary earned in the last year of work, which is usually increased with night shifts and extra time. On the other hand, they have preserved the “*retroactividad en las cesantías*”, even though the new labor law abolished this practice.

⁹⁷ Probably this was not a result expected by the reform.

included in the ISS Benefits Package. There also appears to be a lack of information and knowledge about how to change the system.⁹⁸

However, at the same time there seems to have been a migration of groups with higher levels of income from the ISS to private EPS. Even when the impact in terms of UPC is not important (because it is not related to income level, but to a risk adjusted premium), it can affect the institute in terms of number of members by family (which tend to be higher in poorer families) and sickness propensity (that can be higher among the poor). This pattern is related with a process of segmentation that seems to be developing within the system in which some EPS, particularly the private ones, are concentrating their drive for affiliates on people with higher wages.

The transition for the ISS has been difficult because the institution has resisted many aspects of the reform. They have delayed the introduction of key aspects such as the definition of the Benefits Package content, the co-payment measures, the compensation mechanisms, and the separation of funding and provision of health services. Until 1998 the Institution had not even revised its data and management systems to separate payroll-based contributions for pensions and for health care. Administrative and financial problems, the unions, political will of the director under the Samper government, and the patronage practices within the Institution, had made the transformation extremely difficult. If this institution, which is the most important one within the contributory regime, has changed but not according to the principles of the reform, to what extent can we say that the reform operated within the contributory regime?

Subsidized Regime

The Institutions

Within the subsidized regime, institutional growth and transformation has been important as well. At the end of 1997 there were 205 ARS working in almost every municipality and affiliating 7 million poor. Of the total number of ARS, 19 are EPS, 27 CCF, and 159 “*empresas solidarias de salud*” (ESS). The institutional diversity within the system is very important.

In spite of this important dynamic and the affiliation levels they have achieved, those institutions present more problems than the institutions that manage the contributory regime for the better off. The most important difficulty is financial viability due to the small number of affiliates in many of them and their low levels of capital. This situation can lead to problems with the risk distribution probability and can result in the lack of financial stability and therefore non-fulfillment with the Benefits Package services provision. A case in point (but not the only one) is the ESS, which are very important in the affiliation of the poorest, particularly in remote regions.⁹⁹ In spite of their advantages, their size can be a problem for their sustainability and they can not provide adequate services in the case of sicknesses requiring high cost treatment (DNP, 1999).

On the other hand, some resources of the subsidized regime are being diverted through the affiliation of non-poor people. In addition, there is not enough information for the users who in turn do not demand services. Therefore, the resources do not flow to the health provider institutions. This situation has contributed to worsen the financial difficulties of the IPS. Finally, most of those ARS are not accomplishing all their functions. For instance they are not promoting health and preventing

⁹⁸ However, problems in quality and opportunity of services, more information, and the prohibition in 1998 of affiliating more people until the institution can resolve its crisis, seem to be producing disaffiliation from the ISS and favoring the growth of other EPS in terms of the number of affiliates.

⁹⁹ This program was the one Gaviria’s government wanted to promote instead of the reform. In this case the affiliation with the health system is done through an ESS. This is a community organization that can manage resources like any ARS.

sicknesses. Therefore, for some actors of the system, they are seen as resources intermediaries, and this has generated resistance towards the health reform in the subsidized regime, particularly from providers, health sector workers, and local authorities (DNP, 1999).

Decentralization Process.

Within the subsidized regime, local and departmental governments have been key actors in the implementation of the health reform, due to the decentralized framework established in Law 60 within which Law 100 has to operate. The new subsidized regime is defined by both Law 100, 1993 (Social Security Reform), which gives priority to the principle of demand subsidies, and Law 60, 1993 (Decentralization Reform), which emphasizes supply subsidies for the health sector. Those contradictions are at the source of many problems for the subsidized regime, particularly at the local level, and within different levels of territorial authority. They have also contributed to the difficulties in implementing the health reform particularly in the case of the subsidized regime and at the local level. Those problems have not been faced by the contributory regime, which answers to different incentives, mainly those established in the Health Reform legislation (DNP, 1999).

In general, the system seems to be working better in large cities and in some medium-sized cities where public services and competition from private providers are stronger than in small rural areas. On the other hand, within this regime there is also great complexity in the allocation of resources because they come from different sources (municipalities and departments), and there are many actors with different interests. This generates confusion and contributes to the avoidance of responsibilities and conflict among actors.

Beyond that, particularly at the beginning of the reform implementation process, there were changes in the direction the subsidized regime was taking, which created confusion at the local level and reinforced resistance to the reform. This regime was the one most affected during the process of transition. The difficult transition from supply to demand subsidies has also affected this regime, as explained below.

Transition of the Old Actors and Public Hospitals.

Within the reform, the transformation of the old institutions and the historical use of resources proved to be far more difficult than the operation of the new actors and the use of new resources. The inertia and resistance to change of the old actors have posed formidable obstacles.

Within the contributory regime, the ISS and the institutions providing health services for public workers had a period of two years to change according to the new system. However, their change has not been satisfactory as was shown in the case of the ISS. In addition, those institutions in some cases continue providing different POS, do not charge the established contribution, have been reluctant to introduce co-payments, and have moderated quotas.

The inefficiency of public hospitals was one of the main reasons for the reform, but it has proven to be one of the main obstacles for the transformation as well. The transition of many health providers, particularly public hospitals, into autonomous enterprises, has either been difficult, or has not been possible at all in some cases. Within the reform, public hospitals have to be self-financed: funding will depend on costs of services provided, not on up-front budgets. They also have to be more efficient. This is a key component of the reform, and a pre-requisite for the transformation of supply subsidies into demand subsidies. Until this transition is complete, it will be difficult to liberate enough resources from supply subsidies to pay for the demand subsidies. Therefore, the expansion of coverage within the subsidized regime is at risk because the new resources for each sector have already been

exhausted, and the increases in coverage depend upon the transformation in the use of those existing resources.

For the transition period it was decided to continue providing hospitals with budgets for several years but on a declining basis, while phasing in the system of filing claims for reimbursement for patients treated. However, this temporary mechanism, does not seem to be disappearing as soon as expected by the reform. During the beginning of the implementation process those institutions received both supply and demand subsidies, sending the wrong signals and incentives for the transformation as they accumulated more resources than ever before. This money was allocated without increasing coverage in the subsidized regime or improving efficiency.

In spite of some progress, in general public hospitals have found the new arrangements difficult and confusing. Private hospitals that provide 40% of the services in large cities, on the other hand, are better organized.

However, the problem of the transition is not explained only by inefficient hospitals. Those hospitals have other inflexibility for the transformation such as the human resources management rigidity (some people can not be removed); outside definition of wages and patronage interference. In addition to that, because the demand for services within the subsidized regime is low, the resources do not flow from the ARS to the hospitals as expected. To sum up, they have to cover the “vinculados” and health interventions within the subsidized regime not covered by the POS-S. Delays on the transition are also explained by confusion, particularly at local level and contradictory development of the Law.

In spite of the problems, some progress has been made and some public hospitals have been transformed into State Social Enterprises: this has been the case of 35% of IPS at the first level and 74% of IPS in levels II and III (Paredes and Plazas, 1998). Moreover, while in 1994 91% of the public hospitals had self-funding levels of less than 40%, in 1996 this percentage was 72%. However 50% of public hospitals can not fund 50% of their expenditures and this is particularly true when they cover interventions with high levels of complexity and in the case of the public hospitals of the poorest regions.

In the case of health providers there also seems to be a process of segmentation which does not favor public health providers. The private IPS are concentrating on interventions with low levels of complexity, while public hospitals have been specializing in interventions with high levels of complexity, high costs, and low demand.

To conclude, the prolongation of the transition period has become an obstacle for achieving the reform’s objectives of universal and integral coverage due to tangible bottlenecks. Among those are the lacks of resources to increase the affiliation and the interventions covered by the subsidized regime.

Other Institutional Requirements

In spite of the important institutional development that has happened as a result of the reform, the implementation of the law has encountered important institutional obstacles. During the beginning of the implementation process, the Ministry of Health authorized territorial authorities to manage, finance, and provide the services of the subsidized regime. This ran against the logic of the reform of separating functions (funding, affiliation, and attention) and also eliminated competition and the demand subsidy allocation principle. In addition, there has been the absence of a reliable and unified information system on affiliation, funding, and costs, which can support the health reform.

There are other institutional problems as well, primarily in the Health Superintendency and the Ministry of Health. In spite of the Law, efforts to establish a strong Superintendency and to adapt the

MOH to the reform, have not been enough. The reform has imposed important demands on them, but they have not been able to respond as they should because they are weak institutions, with high turn over rates, occasional corruption, and bureaucratic resistance.

Another institution developed by the Law was the CNSSS. Even when it initially played a passive role due to its lack of technical capacity and its limited advisory role, it has gradually become stronger and is beginning to play an important role within the reform. In addition, and as a result to a ruling by the Constitutional Court, their decisions now have autonomy, which has given them more power. However, the CNSSS is still dominated by the MOH, and some actors within the health system do not feel effectively represented.

Human Resources

Many doctors and health workers are unhappy with the system. They complain about their incomes, but different studies do not confirm that fact.¹⁰⁰ Doctors are concerned about the income of their profession, but research suggests that this has not been a real problem. On the contrary, the general practitioner has seen his/her salary increase. There do seem to be some problems, but basically they can be explained as a result of the growing number of health professionals that are being graduated by the education system, and the fact that most of them want to work in the same areas.

It is also important to point out that as a result of the Law, which calls for equilibrating public sector health workers salaries with those of other public sector workers, the health workers salaries have had annual increments of 5% above inflation between 1995 and 1998, while for the rest of the workers the increases have been tied to the inflation rates. This situation has benefited the workers but has also generated financial difficulties for the government. Among specialists, there is agreement on the fact that those increases in wages have absorbed funds which might have been used in helping public hospitals to strengthen their data systems and administrative capacity, thus furthering the reform. Even more, public hospitals and public IPS can not compete with other providers in the same conditions, due to the high wages of unionized workers.

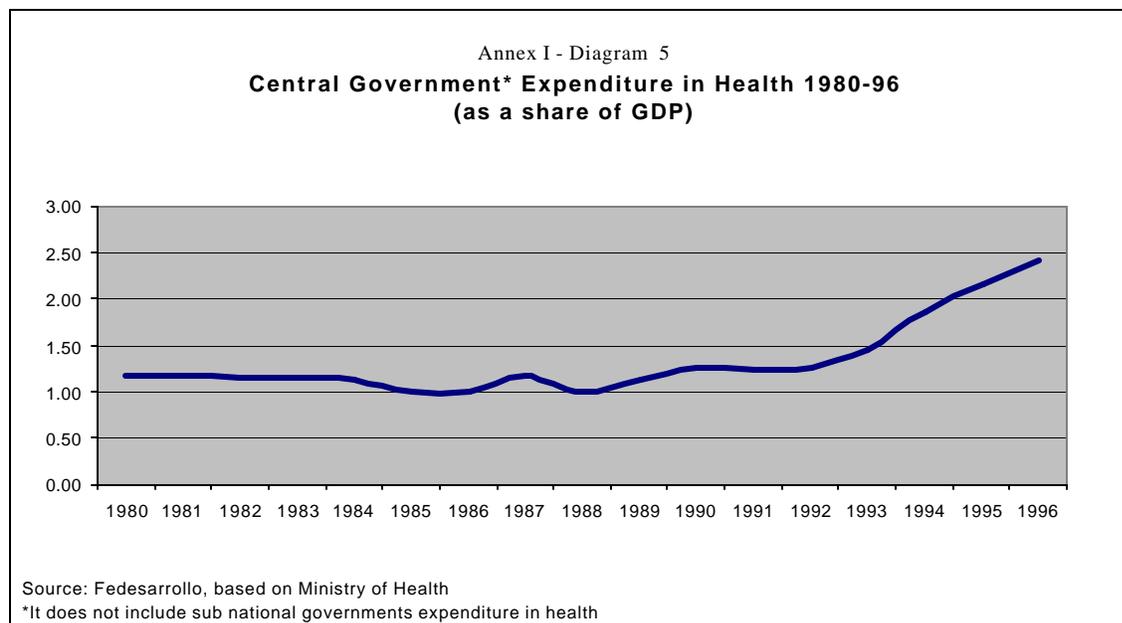
But the doctors' dissatisfaction seems to be related to their loss of control to non-medical personnel and organizations. The reform introduced many changes in the organization of human resources and has transformed their work and power relationships, particularly with the introduction of intermediaries between doctors and patients—i.e., the EPS—and the necessity to introduce efficiency and competition criteria. This has led to important resistance by the health workers who did not feel adequately consulted during the Law's discussion, even when the main heads of their representative bodies were consulted.

As a result of the health reform implementation, doctors associations, that were traditionally been fragmented, and that did not have much power during the discussion of the reform, are now merging and becoming active actors.

THE SYSTEM'S RESOURCES

As a result of the health reform, new resources for the sector were defined, particularly through sub-national levels. This was reinforced with Law 60 1993. On the other hand, the reform changed (or should have changed) the allocation of existing resources.

¹⁰⁰ The Foundation Corona has made studies in this area and there was also a study sponsored by the doctors' association that found little change for most categories of practitioners and sharp increases for others. Other analysts point out that a high proportion of the new resources has been channelled into salaries and wages.



According to Fedesarrollo (1998) public expenditure in health has increased in a significant manner. While during the eighties health expenditure was around 1.2% of GDP, since 1993 the resources have increased. Between 1993 and 1996 the resources for health grew 21.1% yearly and in 1996 they were 2.41% of GDP. Currently Colombia is a country that spends more than the average for countries with the same level of resources. It is not possible to maintain this level of growth in spite of the fact that coverage is not yet satisfactory. This is a bottleneck because the expansion of coverage has to be done with more efficient use of the existing resources and finishing the transition from supply to demand subsidies to eliminate the double allocation of resources. This transition requires the transformation of old actors and resources within the system—one of the greatest obstacles in the implementation of the reform.

One of the mechanisms to analyze the resources of the system is through the study of the FOSYGA accounts. FOSYGA is a very important financial instrument, particularly for solidarity and compensation within the system. It functions as an account of the Ministry of Health managed by a fiduciary and the CNSSS determines the utilization and distribution of resources. It has four accounts: compensation within the contributory regime; health promotion; interventions in health as a result of catastrophic events, transit accidents and emergencies; and the solidarity account.

According to Cuartas (1998), in spite of evasion and avoidance, the FOSYGA resources are 0.7% of the PIB. Even though the resources of the FOSYGA have increased dramatically between 1995 and 1997, there are still problems in accomplishing the reform objectives, particularly with the subsidized regime. The expenditure of resources from this account has been lower than its resources permit; the main reason has been fiscal policy. The government has established annual expenditure plans that have prevented the FOSYGA from spending the total amount of resources they are collecting. In 1996, for example, the FOSYGA spent only 88% of the authorized resources and in 1997, even less (78%). In terms of the resources collected, its expenditure has been only 65% of the resources. On the other hand since 1998 there seems to be a problem of inadequate resources to meet the demands of the system.

1. Contributory Regime

The contributory regime is funded with a pay-roll tax on family added income. As a result of the reform, this contribution increased from 6% to 12% of the family income. This was done to expand coverage in social security from the affiliate to his/her family and to provide an integral package of services.¹⁰¹ The contributory regime should achieve equilibrium with those resources that are intended to cover the Benefits Package of its affiliates and their families.

One of the main problems with the resources for this regime is evasion: of which there are two types. One type of problem is when a person who has to enroll in the contributory regime does not do it at all; the other is when he does enroll, but with a reported income lower than his real one. This situation is present particularly among independent workers. According to the ECV (1997); the main reason for the absence of affiliation was the lack of resources (48.9%). However, there are significant numbers of people who have private health insurance, and do not belong to the contributory regime even when it is an obligation. This group in general is comprised of people who have high income. In some cases the employers are asking their workers to affiliated with the subsidized regime, thereby evading their responsibilities in social security terms (DNP, 1999). This problem is reinforced by the non-existence of adequate information within the system that could help provide better controls.

In the case of the contributory regime it is important to analyze the behavior of the compensation account within the FOSYGA. Every EPS collects the contribution from its affiliates, but what they actually have the right to receive from each of them and his/her family is the UPC, which can be higher or lower than what is collected. If an EPS has surplus between what it has collected and its UPCs, it sends it to the compensation account that redistributes them to EPS with deficits to help them finance their UPCs. Until 1997 the compensation account had surplus. However, it is also the case that up to this point, the ISS (that represented 63% of the contributory regime) had not wanted to be part of that system. It seems that recently the ISS does want to get into the compensation system and if this happens, the account will run a deficit because the ISS is reporting significant differences between what it has collected for the contributory regime and the UPCs of its affiliates. This is probably due to the lower average wages and the greater family size of its affiliates in comparison with the overall averages in the system. It is also relevant to point out that since 1998, the income of the compensation account has decreased as a result of the rise in unemployment levels and the problems of evasion described before (for instance the average wage per contribution has decreased). This situation has affected the collection of resources from pay-roll taxes for the contributory regime. This situation also has affected the solidarity account, which receives 1 point out of the 12 points collected in the contributory regime. This account has an important weight in the funding of the subsidized regime (Cuartas, 1998).

¹⁰¹ However, this new tax on wages also has had an important effect on production costs. In the case of employees, the contribution is paid 2/3 by the employer, 1/3 by the employee. In the case of independent workers, they have to pay the totality of the contribution. In addition, the social security reform increased the contribution for pensions from 7 to 13 points, paid in the same way by employers and employees. Finally, employers have to pay 4 points to the CCF, 3 points to ICBF, and 2 points to SENA.

Subsidized Regime

The subsidized regime has different sources of funding than the contributory regime, including the solidarity account of the FOSYGA, which collects 1 point of the contributory regime and should have a matching amount from the national budget; resources steaming from the CCF, Cusiana and Cupiaga; and social IVA. Those resources are sent to territorial authorities to co-fund the subsidized regime in their territories where they are matched with other resources coming basically from *situado fiscal*, municipal participation, and own-generated resources (i.e. local taxes).

In relation to the contributions of the National Budget to the subsidized regime, it is important to point out that during 1995 and 1996 the resources were not allocated as established by Law 100. In 1996, Law 344 (a Law promoted by the Finance Ministry to improve fiscal efficiency) diminished the resources that central government had to allocate for that regime. Those resources, from being at least the same amount as the point collected in the contributory regime, were reduced to ¼ point or less of the percentage collected. In real terms, the new law reduced by 75%, the State's commitment in co-funding the subsidized regime.¹⁰² This situation was accompanied by fiscal problems at the central level, but also by the excess of resources for the reform at the beginning of the implementation process, that were not being efficiently spent.¹⁰³

While the Law establishes that the CF should invest in the subsidized regime, they had made use of an article permitting them to directly provide the services of the subsidized regime without having to transfer resources to the FOSYGA. Therefore, the FOSYGA has not received the expected resources from those institutions; instead, the CCF have been able to be part of the system but retaining control over its resources.

It is important to point out that resources for the subsidized regime have been allocated as supply subsidies to public hospitals, particularly in violent regions. This has had to be done to cover interventions, which are not included in the POS-S, and to pay for the attention of the “*vinculados*.” In addition, and as a result of the deficit in public hospitals, resources for the subsidized regime have been allocated to them. Therefore, as a result of policy and political pressures, resources that should go to the subsidized regime and be distributed in accord with the demand subsidy principles, have been diverted to supply subsidies. This situation maintains the old health system and goes against the implementation of the health reform.

The problems of evasion and “avoidance” in the contributory regime also affect the subsidized regime, because one point of the contributory regime goes to funding the subsidized one. In addition to those problems, resources do not flow easily, which contributes to the creation of financial difficulties, particularly for the IPS. This situation is present both at the national level when resources have to pass from the FOSYGA to the local funds for health and at regional levels where some majors and ARS do not use them fast enough. When the ARS do not receive the resources on time they can not pay the IPS as fast as they should.

¹⁰² At the same time that Law made compulsory the contract of 40% of the ESS with public hospitals without considering its efficiency and quality.

¹⁰³ This situation originated in various facts. First, the Law established that the collection of new resources for the system should begin before the implementation of the reform. This situation, together with the slow start of the subsidized regime and the coexistence of both demand and supply subsidies at the beginning of the reform, contributed to the feeling of an excess of resources for the system. However this situation was only temporary.

Resources at Local Level

Within the subsidized regime, there have been important increases in resources at the local level. In many municipalities health now accounts for 30% of the budget when it used to be 10%. Law 60 and Law 100 have guaranteed important new resources for health and also decentralization mechanisms. Between 1993 and 1996 the resources for health transferred from central government to territorial authorities have increased from 0.6% of the PIB to 1.2%. This represents 53% of the sector resources. With those resources, there has been important progress in affiliation.

This has given health a new political dimension at the local level and it seems that this situation has been related to patronage: for instance, the carnets identifying their holders as eligible for free or almost free service at hospitals are supposed to be distributed according to living standards. However, there are cases where the major or local council distributes them in exchange for votes.

There are a number of problems that can affect the expansion of the subsidized regime. According to Duarte (1997), the main ones are:

- The diversity and complexity of funding sources. In some cases the same sources have different objectives (e.g.: the “*situado fiscal*” has to fund the subsidized regime, the PAB, and public hospitals). On the other hand some objectives are funded by different sources (for instance the subsidized regime which is funded by the national budget, FOSYGA, and local resources) In addition to the difficulties of administering those resources, the law does not specify at what level or which agency should concentrate them. This situation has led to administration problems, conflict within territorial levels, and in some cases overlapping of funding or no funding at all of some activities.
- The criteria for allocation of resources do not follow the health sector requirements. The objectives of resource allocation are redistribution, increasing the fiscal effort, and increasing coverage in health. But the same instruments are used for all these objectives and this has created inefficiency in the allocation of resources.
- There is confusion over competencies and responsibilities by territorial level. This is particularly true for the PAB and hospitals. While Law 100 establishes demand subsidies to fund hospitals; Law 60 gives that responsibility to departments and municipalities according to supply subsidies.
- For the subsidized regime there is not an instance with a clear delineation of responsibility, rather many institutions are involved. This situation has also contributed to the difficulties in the implementation of the subsidized regime.

There are problems of transition from supply to demand subsidies. This situation has resulted in the existence of overlapping resources for the sector without an equal degree of improvement in health access and conditions (Duarte, 1997). For instance, at least at the beginning of the implementation process, public hospitals were receiving resources both according to demand and supply subsidies without increasing coverage as a result of the transformation of supply subsidies into demand subsidies. Within three years, from 1995 to 1998, Law 60 and 100 multiplied by three times the fiscal resources for public health and the subsidized regime. However, it seems that these resources were not used efficiently enough, (particularly at the beginning of the implementation process) and the coverage has not increased as expected. According to Jaramillo (1997) part of these resources never left the national budget, another part was used for “equilibrating wages,” or was used in other social sectors. The allocation of fresh resources to wage increases was particularly acute during the transition period. As fresh resources started accumulating at the national and sub-national levels due to the reform, unions and doctors took advantage of the situation to demand increases in wages without any improvement in health provision.¹⁰⁴

¹⁰⁴ According to Jaramillo (1997), 3 million people could have been covered with those wage increases.

At the local level, one of the key problems with the resources is that even when they reached important levels, this situation did not go together with the decrease in supply subsidies. This generated a temporary increase in the amount of resources for hospitals that in some cases contributed to inflation of the services, higher wages, hiring new staff, and even corruption. The health services improved somewhat, but not as much as expected with the amount of new resources the system received. Case studies in the region of Antioquia suggest that income and expenditure have grown more than services, which reflects a decrease in productivity within the system (Restrepo, 1998).

The subsidized regime includes new resources and reorientation of old ones. However, the achievements in affiliation until 1997 are explained primarily by new resources for the contributory regime from the solidarity account, new resources from the “*ingresos corrientes municipales*,” and the “*situado fiscal*.” Nevertheless, the resources of this regime have had pressure from hospital deficits, in part explained by the wage compensation established in the Law and implemented at the beginning of the Samper Government, by the attention of the “*vinculados*,” and the attention of interventions which are not yet included in the POS-S. Therefore, there has not been transformation of resources as expected.

In relation to resources, it can be concluded that without doubt the health sector has increased dramatically its resources both at national and local level. Para-fiscal resources have also increased to finance the contributory regime. In spite of those important changes, the impact in coverage has not been as spectacular as the rise in the resources. This has led to inefficiency, higher costs, and even corruption. In addition, most of the new affiliations have been made with the newly allocated resources, but the change in the allocation of previously existing resources has proved harder than expected. This is a critical condition of the reform, particularly now that the expansion of additional coverage to achieve universal affiliation has to be done based in a more efficient use of the existing resources. Finally, the system is having problems due to evasion and “avoidance” in the contributory regime; the complexity in the funding mechanisms of the subsidized regime and the economic crisis that is affecting all the sources of funding.

THE TRANSITION PERIOD

The main results of the reform in terms of affiliation, institutional development, and resources have been described. However, they have been affected by a transition period, which has had effects on the achievement of the main goals of the reform. The Law established a transition period from the old health system to the one approved by the reform. This period was supposed to last from 1994 to 1996, but it has gone well beyond this. This was a period of adjustment for the institutions such as the ISS, existing social security institutions, public hospitals, and territorial authorities. A gradual transition from supply to demand subsidies was also envisioned. However, the transition has not been accomplished due to changes of direction within the Ministry of Health particularly at the beginning of the process, absence of political will particularly at the local level, insufficient incentives for the transformation, and technical difficulties.

The Beginning of the Subsidized Regime: Decree 2491, 1994

The period of transition was chaotic, particularly at the beginning of the implementation process, and it affected primarily the subsidized regime. During this period, the Ministry of Health established different policy directions and it could be said that there was an attempt at counter reform. Initially, the affiliation process for the subsidized regime was placed temporarily in the hands of the territorial authorities, not the ARS. This was done arguing that there were not enough EPS and ESS to manage the subsidized regime at the time, with the objective of stimulating the affiliation process to the health social security system, and as an answer to the necessity of spending the important amount of new

resources for the sector.¹⁰⁵ But those territorial authorities became an obstacle for the development of the subsidized regime according to the reform, because they were interested in maintaining their monopoly over managing the resources and not in promote the creation of ARS. On the other hand, they used demand subsidies to affiliate poor people to the regime and to continue funding hospitals at the same time they were receiving supply subsidies (Paredes 1999).

This situation sent the wrong signals, because it was the continuation of the old system. Therefore, this decree promoted a kind of counter-reform within the subsidize regime, that reinforced the position of some actors who were against the changes such as public hospitals, health workers, and in some cases territorial authorities.

In February 1996, the new Minister of Health, Augusto Galán, promoted new Executive legislation to recover the initial spirit of the reform: Decree 2357, 1995. This has stimulated new dynamics within the system according to the principles of the reform. Nevertheless, this early period of transition reinforced the resistance to change of the traditional actors within the health sector.

Slow Development of Key Instruments of the Reform

According to González and Pérez (1998), the transition has been particularly difficult within the subsidized regime and also for the ISS that in turn is the biggest EPS within the contributory regime. There are two main problems: opposition by doctors and health sector workers, and the transformation from supply to demand subsidies.

As this annex has shown, the subsidized regime has two sources of funding. One source is new resources resulting from the reform and Law 60, 1993 have been used to increase in a significant manner the affiliation of the poor to the social security system, that is now 47%. However, the other source is the transformation in the use of old resources, which is necessary to achieve universal and integral coverage of health. This second part of the reform faces important obstacles.

One of the key points of the reform to promote equity was that the Benefits Package of the subsidized regime had to be equal to the one of the contributory regime by the year 2001. Even when the Benefits Package content has been extended to cover high cost treatments such as cancer, it will not be possible to have the same package for both regimes. The priority is to increase the affiliation to achieve universal coverage. Besides being an obstacle for equity, this situation contributes to the prolongation of the transition regime, particularly of the supply subsidies for public hospitals, who can not cover the interventions contained in the Benefits Package and that currently are not included in the Benefits Package of the subsidize regime.

This situation is reinforced by the need to cover the attention of the “vinculados.”¹⁰⁶ It is difficult to end supply subsidies and replace them entirely by demand subsidies. The transition is necessary while the POS-S is still partial and while there is no more expansion of affiliation because the “vinculados” have to be attended.

For some people the problems of the transition are mainly a problem of political will. But González and Pérez argue that there is a problem of incentives for the transition. They argue that the transformation of subsidies should be a result of public hospitals being able to be self-financed. Until

¹⁰⁵ The Law approved a period of one-year preparation for the operation of the Law, but authorized the collection of new resources beginning at the law's approval. This factor explained the accumulation of resources at the beginning of the implementation process.

¹⁰⁶ People living in poverty, whose health should be covered by the subsidised regime but have not been affiliated to the regime, due to scarcity of resources.

they do not achieve that equilibrium they will need supply subsidies as well as demand subsidies. And this situation will delay the coverage of the subsidized regime.

At local level there is no incentive for changing the flow of resources, because territorial authorities do not want to lose power. They are not interested in promoting the affiliation and health service provision to institutions that are not controlled by them, even less when they are financing those services to an important extent. They do not have incentives to separate affiliation from provision and in promoting competition, and those are key elements of the reform. Funding and provision are still in the hands of local authorities.

ASSESSING THE REFORM'S OBJECTIVES

This section assess the main achievements of the reform in terms of the main objectives defined for the reform: universal coverage by the year 2001, solidarity, and efficiency. The reform was approved in December 1993 and its implementation began in 1995 after a one-year period of transition.

IMPACT ON COVERAGE

One of the objectives of the reform is to achieve universal affiliation with the health component of social security by the year 2001. This in turn should be reflected in universal coverage for health. Analyzing the results reveals that there has been important growth in affiliation with social security; nevertheless, it will not be possible to achieve universal coverage by the year 2001. This is due to the lack of resources to increase the affiliation under the subsidized regime. In addition, affiliation in and of itself does not guarantee access to health services nor does it guarantee improvement of health conditions. However, it is important to point out that the reform tried to remove the main obstacle to access which, according to the ENH 1992, was lack of money for services. Through the affiliation of the poor with the subsidized regime, the population at large people has been provided with this asset.

In 1997 it was observed that the utilization of health services among the affiliates with the social security system was not homogeneous. Individuals covered by the subsidized regime have lower rates of use of health services than those in the contributory regime. In general, they use health services only in emergency cases. This situation has been attributed to lack of information among this population about the rights given to them by the new system. This, in turn, has been attributed to the poor promotion of EPS and ARS which has been limited those to information leaflets.

Lack of access is also a problem for public hospitals. The resources do not flow to them according to the demand principle subsidies, because people belonging to the subsidized regime use the services only in emergency cases.

Access for the poor is also affected by long distances, lack of information, and problems with SISBEN, which does not always identify the poorest, often as a result of technical or patronage problems. The problems of access to health care are more important among the "vinculados" and especially in rural areas and within groups of people with lower education and income.¹⁰⁷

Therefore universal coverage by the year 2001 will not be possible in terms of affiliation and even less in terms of access. This is true for the subsidized regime, but also for people that should be in the contributory regime but find the contribution too high to be paid. This is particularly true for groups

¹⁰⁷ Econometría, "Análisis de la Encuesta de Calidad de Vida", 1997 in Health Division, DNP.

with middle or low levels of income, and for the independent workers who have to pay the whole contribution by themselves.

EFFICIENCY

Efficiency was one of the key points of the reform and it was an element of the new health system established by both the Constitution and the Law. The main strategy was to introduce managed competition for the affiliation and provision of services, but also to allocate resources with greater efficiency. The change team tried to introduce instruments to increase efficiency such as the Benefits Package definition, the UPC, and competition. However, it is the case that those instruments were not always approved by the reform. And in some cases where they were approved, they have not operated or they have not had the expected results.

1. POS Definition (Compulsory Health Plan)

A Benefits Package, defined according to technical criteria, was one of the instruments that introduced as a means of allocating the resources with efficiency. Following the World Bank guidelines, a methodology based on “burden of disease” was proposed; i.e., resources should be allocated in those areas where the “burden” was important and the interventions cost-effective. This was the criterion that was to have been used for the definition of the POS. This is the reason why the Ministry of Health, influenced by World Bank policies, tried to define a Benefits Package with basic interventions.

Nevertheless, during the discussion of the Law, the change team lost that proposal and an integral package for health was approved, which included prevention, promotion, diagnosis, treatment, and rehabilitation, according to Decree 1650/77. This package was made applicable both to the affiliate and his/her family and funded with the UPC and the contributions. However, based on the available resources at the moment the Law was promulgated, the change team managed to have two Benefits Packages approved: an integral package for the contributory regime and a partial package for the subsidized regime. But, according to the Law, they should be unified by the year 2001.

During the secondary law formulation, the change team tried again to restrict the Benefits Package procedures according to technical criteria. But there were other problems such as the lack of adequate information; a requirement for constant actualization; and criticism that the technical criteria narrowly explained health as the result of only sectorial elements uninfluenced by outside factors. Therefore, in the end, the definition of the Benefits Package for the contributory regime was not based on technical efficiency criteria, but rather on the Decree 1650/1977, which defined an integral package for the ISS affiliates. Therefore, this particular instrument to promote efficiency in the allocation of resources was not used in Colombia.

2. UPC (Risk Adjusted per Capita Payment)

In the case of the contributory regime, once this Benefits Package was defined, it was established that it should be funded with the resources of the UPC plus co-payments. But in practice this has not been the case during the first years of the health reform implementation, even when there is a gradual movement towards this equilibrium. During the first two years of operation, 1995 and 1996, there was a gradual process of adjustment among sources of income between the EPS, which included the UPC, the co-payments and moderate quotas. In 1997 the UPCs represented 80% of their income. Other resources coming from complementary plans, financial incomes, and selling of services to other EPS constituted the rest (DNP, 1999).

The EPS of the contributory regime posted losses during 1995 and 1996, but in 1997 they began to run a small surplus. However, this does not seem to be a problem because when the health reform started, 5 years of initial losses were expected for those institutions.

However there are signals that require attention. The UPC, for example, is lower than the average cost of the Benefits Package offered by the EPS. According to the Ministry of Health, this is probably due to the higher than expected use of health services in the contributory regime and higher medical expenditure. Even when a unique UPC guarantees the same package of services and risk distribution, to consolidate that risk distribution it has been estimated that at least 200.000 affiliates are necessary: However, not all the EPS have achieved that number of affiliates, which makes them vulnerable. The UPC has had a lot of variation. This situation demonstrates that the technical criteria for defining this element of the reform have not been used. The definition has been more incremental and practical. In the case of the subsidized regime for instance, it has been established at half the cost of the contributory regime.

Therefore, in the contributory regime there seems to be over use and high costs. There is tension between client satisfaction and cost control. But the problem in the subsidized regime is that there is no relationship between the resources that are being allocated and effective access. Therefore, the impact of the UPC on health expenditure efficiency is not yet clear (Cuartas, 1998).

3. *Competition*

One of the main tools designed by the reform to induce efficiency was competition both in the affiliation and the provision of services. However, this has not always been possible, particularly within the subsidized regime. It has not been possible to introduce competition in all regions and there are health interventions where competition has not happened, especially in the case of complex medical procedures (González and Pérez, 1998).

On the one hand, at the local level, particularly in small localities, there is no possibility for competition. On the other hand, the Law forced the ARS¹⁰⁸ to contract 40% of their services with public IPS without having to take into consideration efficiency measures. Finally, there is no easy way to introduce competition in health services requiring high complexity. That helps explain the proliferation of private IPS in charge of simpler procedures, while high-cost treatments remain a natural monopoly of some specialized institutions, usually public hospitals.

It is not always easy to separate the process of demand and supply of health services. This is the case of the ISS, which enrolls 63% of the beneficiaries. This institution acts both as EPS and IPS without clear division between the two. This is also the case of health affiliation and provision of services in some regions within the subsidized regime.

Efficiency mechanisms have been defined more as a result of practical demands than of technical arguments. This has certainly been the case of the Benefits Package content and the UPC, although they do function as indicators for the efficient use of allocating resources, and have shown a trend towards improving efficiency particularly within the contributory regime. Other key elements of efficiency such as competition and free choice have not developed as expected, particularly within the subsidized regime. Another obstacle to increased efficiency has been the non-separation of the affiliation and provision functions, particularly among old actors of the system such as the ISS and territorial authorities. Therefore, even when there have been developments that can help to promote efficiency, particularly within the contributory regime, obstacles remain.

EQUITY AND SOLIDARITY

The reform has contributed to greater solidarity in access to social security and health services. Within the contributory regime a compensation system that promotes solidarity has been put in

¹⁰⁸ Public Expenditure Rationalisation Law, 1996.

motion. There has been important progress in affiliation with social security of the poor population and extension of affiliation to almost every locality in the country. In addition, the introduction of family coverage has benefited many, particularly women and children, in both regimes.

However, in spite of this progress, problems of inequity persist. According to the ECV (Encuesta de Calidad de Vida) 1997, within the poorest group of the population, 60% do not have any affiliation while in the richest one this percentage is only 16%. However, it must also be pointed out that there has been an important increase in the affiliation of the poor which has risen to 40% (DNP, 1999).

There are also problems with the targeting process and there is evidence of non-poor having been affiliated with the subsidized regime. According to the ECV (1997), 1.3 million of non-poor (deciles 6 to 10) were affiliated with the subsidized regime: with those resources 1/3 or the poorest people (decile 1) could have been affiliated. This situation seems to be a result of the politicization of the SISBEN, because at the local level it is been used as a patronage resource. On the other hand, there is no reliable information system that can help to detect those problems (DNP, 1999). This situation has a negative impact on the achievement of the equity objective.

There is also inequity by occupation. Among independents, domestic workers, and laborers, the level of affiliation is under 50%. In general they are not poor enough to belong to the subsidized regime, but for them affiliation is still expensive. There are still problems of inequity due to the lower use of health services of the people belonging to the subsidized regime, the "vinculados," and inhabitants of rural regions.

Another problem is that even after the promulgation of the Law and the important amount of new resources for health, every household still spends a significant amount of its income on health and this is very unequal. According to the ECV (1997), 80% of Colombian households make out-of-pocket payments for health care every month. Including the cost of affiliation, this expenditure is more than 10% of the household income. In the case of the subsidized regime this seems to be due to the non-fulfillment by the ARS on providing services that the affiliate can use, such as medication, diagnosis support elements, and the practice of sending patients to other places. The service is therefore inefficient and the consequence is inequity in health expenditure. Families belonging to the subsidized regime also spend 10% of their income in health, but this case is even worse because it does not include the cost of affiliation which for them is free (DNP, 1999).

Inequity also persists because there are still different systems of health provided by different institutions and under different conditions, even when the Law wanted to abolish those privileges. This situation applies mainly to public workers who were covered by those systems before the promulgation of the reform. Even when the Law established that those institutions had a 4 year period to adapt to the new system, offering the same POS, charging the same contributions, and entering the compensation process of the contributory regime, the old health provider institutions still offer a more comprehensive Benefits Package and in some cases have delayed their transformation.

Within the EPS, there are 15 that are authorized to manage both the subsidized and the contributory regime. For them, between 1996 and 1997 the incomes coming from the UPC of the contributory regime went from 15% to 27% of their income. However, in 1997, 50% of them were able to use those resources to cover their deficits in the contributory regime due to the low use of services by the subsidized regime. Thus, they were able to obtain a net global surplus. This situation reflects inequality between the two regimes, because resources from the subsidized regime are being used in favor of the contributory regime (Cuartas, 1998).

One of the rationales of the reform was to abolish the system's fragmentation and privileges. Even when there have been significant achievements; segmentation has not been eliminated from both affiliation and provision of services. There seems to be fragmentation within the institutions that affiliate people. This fragmentation is both within the contributory regime and between the two

systems. Within the contributory regime, some EPS have been specializing in affiliating groups with higher income, particularly in the biggest urban centers. While the average base for payment is 1.8 minimum wages in the ISS, the average for the system is 2.2 minimum wages. In addition, in the ISS, the people affiliated with the system have larger families. Third, there is also segmentation between private health providers and the public providers, because the latter concentrate on interventions with high costs.

In relation with other principles of the Law such as integrity of care and improvements on quality, even when there have been advances, they are a secondary priority in relation to the expansion of affiliation and coverage. Even when the Benefits Package content of the subsidized regime has expanded, it will not be possible to accomplish the goal of having the same Benefits Package for both regimes by the year 2001. Therefore the system has not been able to offer a unique package for every one, without reference to their level of income, and this problem lies at the center of a fragmented system divided on the lines of income.

In relation to quality, according to the ECV (1997), 85% of the people received attention in health when they required it and 83% thought it was good. However, there are problems with quality due to the lack of an accreditation system for health professionals and institutions, and the number of people on the waiting list for surgeries (DNP, 1999).

CONCLUSIONS

The reform has promoted significant transformation within the health sector, and in spite of many difficulties, has obtained significant achievements. The main gains have been

- the increase in social security coverage from 20% to 53%;
- family coverage;
- the generation of dynamic institutions within the contributory and the subsidized regimes that have contributed to the expansion of the affiliation; and
- important new resources for health, both fiscal (national and sub-national) and para-fiscal.

Those achievements have been reflected in the improvements in access to health, greater equity, and moderate increases in efficiency within the contributory regime.

Nevertheless, and in spite of the progress made in a short period of time, many problems persist. Even when there have been important improvements in relation to the objectives of the reform, it will not be possible to achieve them in the time envisioned. The implementation of the reform seems to be going through a process that is putting at risk its present and future achievements. Although affiliation has increased, it has not been always reflected in better access to health services, particularly for the poorest groups of the population. The achievement of universal affiliation by the year 2001 with the same Benefits Package content for both regimes will not be possible.

In spite of the infusion of significant new resources for the sector, improvements in coverage have not been as expected and there are financial constrains for its expansion. One of the main reasons is the unfinished transition of the reform, both as a result of political and technical problems. In particular, the old actors of the reform have encountered great difficult with the transformation envisioned in the Law as well as with the allocation of existing pre-reform resources for new ends. Significantly, the fresh resources allocated to the sector as a result of the reform have failed to be directed towards expanding coverage or consolidating policy change. Instead, they have been diverted to help cover wage increases for health personnel. It can be said that the important achievements of

the reform have been done primarily with the new resources and through the new institutions, but the old institutions that existed before the reform have been very difficult to change.

It is cause for concern that a process of segmentation is developing between the two regimes—contributory and subsidized— but also within different groups of income in the contributory regime and between private and public health providers.

In addition, the subsidized regime, which should cover the poorest, is the one with more problems that presents greater obstacles to change. They face financial and institutional difficulties and this is reflected both in insufficient coverage and quality. Finally, within the contributory regime, the ISS (which covers 63% of that regime) has found it difficult to work under the new principles developed by the reform. The ISS, the most important actor within the contributory regime, is in a difficult situation, and unions and political pressure make the changes even harder to obtain.

Therefore, even when there has been important progress in the sector as a result of the reform, this has been basically as a result of the new actors and resources of the sector, while the existing ones have not been modified as expected. On top of that, the improvements are not what were expected according to the amount of resources available and the objectives of the reform.

Besides the technical and administrative obstacles, the political factors in the implementation process have also affected the final outcome of the reform. The main pockets of resistance are health workers, public hospitals, and territorial authorities, and all of which have an impact on the subsidized regime, which is the one facing the greatest difficulties to be transformed according to the principles of the reform. As a result of the Law, different sectors are better organized now, in support of and against the reform: particularly those representing health sector workers and institutions' interests. User organizations have not had a significant development.

According to González and Pérez (1998), the reform implementation has achieved around 60% of its objectives in a short period of time. However, the second stage of the process will be crucial not only in defining the affiliation level, but also in making the reform sustainable. And significant risks lie ahead. What follows is more difficult to achieve, because it has to be done with the completion of the transition process and the transformation of the old actors and resources of the reform.

ANNEX II. CHRONOLOGY OF EVENTS

PERIOD	YEAR(S)	POLICY PROCESS	DESCRIPTION
Historical Background 1940-1950	1940s	Creation of ISS	The ISS was created to provide health insurance and pensions for private formal sector workers. It was funded by employers and employees.
		Creation of social security institutions for the public sector	It was a process that accompanied the ISS creation. It had the same objective, but their beneficiaries were public sector workers.
		Creation of the Ministry of Hygiene	This institution was in charge of general health conditions but it did not have control over hospitals. At the same time, local authorities of health were established.
	1975	Creation of a National Health Service	The new system was comprised of the MOH as the director; local health services, and regional units in charge of hospitals. The central level took control over health issues. The system covered the public sector, social security institutions, and private health providers; however in practice, it only had control over the first one.
	1986	Popular election of majors.	This was one of the first steps towards a decentralisation process that continued until the 1990's.
	1987	IVA	The territorial authorities began to receive resources to invest in health as part of the decentralization process.
	1990	Law 10, 1990	In addition to decentralization of resources, control over health services was established. Provision of health was now under the control of local authorities and the national level concentrated on direction and assistance.
Gaviria's Government 1990-1994	August 1990	Gaviria became President of Colombia	Under his government there was a State Reform which included a process of internationalization and modernization of the economy. The first stage of reforms included the exchange rate regime, foreign trade, financial matters, tax reform, harbor privatisation, housing policy and labor reform.

PERIOD	YEAR	POLICY PROCESS	DESCRIPTION
	January -July 1991	National Constituency Assembly (ANC)	After more than 100 years the Constitution was reformed through an elected assembly, whose members differed from the traditional conformation of Congress. The Assembly mandated new reforms, particularly for the social sector. They included social security, public services, education, planning, central bank, and decentralization.
		ANC proposed a social security reform	The ANC defined the establishment of a new social security system characterized by universality, solidarity, and efficiency. It should include both pensions and health and involve the private and the public sector.
	September-December 1991	Social Security Commission	A Social Security Commission was created by the ANC with the objective of defining the social security reform proposal. Its members met for several months, but in the end they could not agree on a reform proposal.
	September 1992	Bill 155 for social security reform	The Executive, through the Labor Minister, presented a social security reform project to Congress, which did not include health. Congress rejected it and demanded the inclusion of health as part of the social security reform.
	December 1992	Juan Luis Londoño is appointed Minister of Health project as part of the social security reform presented to Congress	The former DNP deputy director was appointed Minister of Health, where he became crucial for the approval of the health reform. Londoño presented to Congress a health project (Empresas Solidarias de Salud) as a complement to the Executive's social security reform proposal. Congress rejected it and asked for a comprehensive reform.
	April 1993	The Executive presented a new social security reform project	A new project, which included a comprehensive health reform, was presented by the Executive. From this moment, Londoño and a change team in charge of the reform, assumed took a central role.
	April-December 1993	Discussion of Health Reform in Congress as part of the Social Security Reform	
	December 23, 1993	Approval of Law 100, 1993.	The social security reform was approved and signed by the President. It included both health and pensions.
	January -August 1994	Health Reform Decree Process.	The new law left the definition of key issues of the reform to an expedited decree process with the Executive, particularly the MOH. Within the MOH there was a change team in charge of the process.
Samper's Government 1994-1998	August 1994	Samper became new President of Colombia	Ernesto Samper, a liberal with different views on the modernization strategy started by President Gaviria, was the President in charge of the implementation of most of the reforms approved after the ANC, including the social security reform.
	1994-1995	Decree 2491, 1994	Alonso Gómez was appointed Minister of Health. He did not share key points of the reform. He delayed its implementation and attempted a counter-reform.
	1995-1996	Decree 2357, 1995	Augusto Galán was appointed new Minister of Health and took measures to revive the reform.

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