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Colombian Law 100 of 1993: between the myth of the market and economic theory.

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Abstract

This essay investigates and interprets the economic, social, and political theories and facts that framed the creation of Law 100 of health in 1993 in Colombia, which are contrasted with the elements contained in its normative and institutional design, to help answer the question of whether this was a neoliberal recipe as suggested by some authors. For this purpose, a hermeneutic exercise supported by critical theory is used, which aims at going back over the facts and questioning in depth the way they have been presented and interpreted. In its development, concepts and realities such as neoliberalism, human rights, health markets and the operational structure of Law 100 of 1993 are addressed. In the end, it is discussed that cataloging health as a scenario in which patients and hospitals freely buy and sell services, ignores the economic theory that considers it an imperfect market, and the evolution of health as a human right, in which, if its laws were left to act without anyone's interference, imbalances would occur that would affect users and those who finance its services. What Colombia did with this Law was to advance in the construction of a universal public social security system regulated and financed by the State in which fewer and fewer patients would have to depend on their own resources and on the laws of the economy to enjoy this benefit, increasingly managed as a fundamental right and less as a commodity.

----------*Keywords:* Information Asymmetry, Right to Health, Health Care Economics and Organizations, Public Health Expenditure, Health Insurance.

Ley 100 de 1993 en Colombia: entre el mito del mercado y la teoría económica

Resumen

Este ensayo investiga e interpreta teorías y hechos económicos, sociales y políticos que enmarcaron la creación de la Ley 100 de salud en 1993 en Colombia, los que son contrastados con los elementos contenidos en su diseño normativo e institucional, que ayudan a responder a la pregunta de si esta fue una receta neoliberal como sugieren algunos autores. Para ello, se acude a un ejercicio hermenéutico apoyado en la teoría crítica que pretende volver sobre los hechos y cuestionar a fondo la forma como estos han querido ser presentados e interpretados. En su desarrollo, se abordan conceptos y realidades como son el neoliberalismo, los derechos humanos, los mercados de salud y la estructura operacional de la Ley 100 de 1993. Al final se discute que catalogar la salud como un escenario en el que pacientes y hospitales compran y venden libremente servicios desconoce la teoría económica que la considera un mercado imperfecto, y la evolución de la salud como derecho humano, en el que, si se dejasen actuar sus leyes sin interferencia de nadie, se producirían desequilibrios que afectarían a los usuarios y a quien financia sus servicios. Lo que hizo Colombia con esta ley fue avanzar en la construcción de un seguro social público universal regulado y financiado por el Estado, en el que cada vez menos pacientes tuviesen que depender de sus propios recursos y de las leyes de la economía, para gozar de este beneficio manejado cada vez más como un derecho fundamental y menos como una mercadería.

----------*Palabras clave:* asimetría de información, derecho a la salud, Ley 100 de 1993, mercado de la salud, neoliberalismo

Lei 100 de 1993 na Colômbia: entre o mito do mercado e a teoria econômica

Resumo

Este ensaio investiga e interpreta as teorias e os fatos econômicos, sociais e políticos que enquadraram a criação da Lei 100 sobre saúde em 1993 na Colômbia, que são contrastados com os elementos contidos em seu desenho normativo e institucional, que ajudam a responder à pergunta se essa foi uma receita neoliberal, como sugerem alguns autores. Para isso, utiliza-se um exercício hermenêutico baseado na teoria crítica, com o objetivo de revisitar os fatos e questionar em profundidade a forma como foram apresentados e interpretados. Em seu desenvolvimento, são abordados conceitos e realidades como neoliberalismo, direitos humanos, mercados de saúde e a estrutura operacional da Lei 100 de 1993. No final, argumenta-se que catalogar a saúde como um cenário em que pacientes e hospitais compram e vendem serviços livremente ignora a teoria econômica que a considera um mercado imperfeito e a evolução da saúde como um direito humano, no qual, se suas leis fossem deixadas para agir sem interferência de ninguém, seriam produzidos desequilíbrios que afetariam os usuários e aqueles que financiam seus serviços. O que a Colômbia fez com essa lei foi avançar na construção de um sistema de seguro social público universal regulado e financiado pelo Estado, no qual cada vez menos pacientes teriam de contar com seus próprios recursos e com as leis da economia para usufruir desse benefício, cada vez mais administrado como um direito fundamental e menos como uma mercadoria.

----------*Palavras-chave:* assimetria de informações, direito à saúde, Lei 100 de 1993, mercado de assistência médica, neoliberalismo

Introduction

The 1993 Health Law 100 in Colombia has been labeled by some authors as a neoliberal prescription that introduced the logic of the market and turned health into a commodity [1-6]. They associate neoliberal policies with events that begin during World War II, followed by others such as the end of the welfare states in 1970, the external debt crisis in Latin America in 1980, the recommendations of the "Washington Consensus" in 1989 and the World Bank's "World Development Report 1993: Investing in Health" in 1993. This essay is a hermeneutic exercise on the theory and the social and economic facts on which the construction of this law was based. It shows that this is a highly imperfect market that existed long before this law was approved, and that when contrasted with its regulatory and institutional design, it is evident that rather than introducing the rules of the market to health in Colombia, their existence was recognized, and a series of measures were adopted to control their effects. Therefore, the design of this law represents an advance in health in Colombia, considering it as a fundamental right of all citizens and no longer only of workers, as was the case before it, increasingly removed from the laws of the market.

Methodology

In the contemporary world, the design and implementation of health systems has become a topic of growing attention and the subject of intense discussions aimed at determining the best organizational forms, the foundations on which each proposal should be based, and the most equitable and efficient mechanisms for financing and access to services, among other relevant aspects [7]. From this perspective, the purpose of this paper is to research and interpret the theoretical and historical foundations on which the public health policy adopted by the Colombian State through Law 100 of 1993 was based, then to contrast it with its regulatory and institutional design. To this end, we examine the economic, social, and political theories and facts under which health markets have operated in the world, to help answer the question of whether Law 100 of 1993 was a neoliberal prescription that introduced the free market in health services in Colombia.

This paper makes a hermeneutic epistemological approach based on the critical theory developed by the Frankfurt School and by Herbert Marcuse as one of its main contributors, motivated by the need to overcome the appearances with which reality has been presented and the naivety with which decisions are sometimes accepted, seeking to discover the true underlying forces in its occurrence [8]. This theory is opposed to the idea that the narrated facts represent an objective, unquestionable and immovable reality, and that, on the contrary, in each of these there is a different meaning for those who perceive it according to their life experience, ideological concepts and interests, and a latent possibility of changing what would seem to be its unquestionable course [9].

Results

The results of the interpretative exercise of the economic, social and cultural theories and facts under which health systems have operated throughout their history are presented as follows. They begin by explaining what has been understood by neoliberalism; then, an approach is made to the meaning of the Right to Health, in order to analyze, in classical economic theory, why health markets are considered imperfect and what are their consequences. Finally, in the framework of the theories and facts described above, an interpretation is made of the institutional and regulatory design of Law 100 of 1993.

The facts associated with the origins of neoliberalism

The expression "neoliberalism" has different meanings and uses in academia, the political world and society in general. Commonly, it implies a negative and pejorative label that some political ideologies associate with absolute evil, or with facts that can have different interpretations, such as those related hereafter, which has contributed to make its meaning increasingly vague and imprecise [10]. Its birth is related to the creation, in 1947, of the Mont Pélerin Society, in Switzerland, led by economists Friedrich von Hayek and Milton Friedman, who supposedly sought to combat the Keynesian welfare states [11]. This was to replace them with the market as the only valid actor in the management of social relations, reducing the State to its minimum expression, an imprecise criticism that in reality was directed at Hitler's Germany and Stalin's Soviet Union.

In their writings, they recognized the complementary role of social and economic policy, and the role of the State in its execution [12-14]. With the reconstruction of Europe and Japan after World War II, led by the United States, the world experienced the greatest economic growth in history, allowing nations to improve the living conditions of their populations, a period known as the "welfare states" [15]. This ended with the world economic recession unleashed by the oil embargo that began in 1973, which increased oil prices more than tenfold. The increased profits in the oil-producing countries were invested in the US banks, which then loaned uncontrollably to Latin American countries and a decade later caused the debt crisis in the region [16]. The Washington Consensus consisted of a series of measures aimed at

stabilizing the economies of the countries affected by the disproportionate growth of their public spending. This was in turn financed with foreign debt, which doubled between 1981 and 1987 as a proportion of gross domestic product (GDP), and came to represent four times the value of exports, making it practically unpayable [14,17]. These measures called for fiscal discipline so that expenditures would not exceed income. This required reducing public spending with measures such as eliminating subsidies that benefited the wealthiest sectors, such as oil, exports, the dollar exchange rate, interest rates or industrial and commercial companies of the State that generated losses, and redirecting them to the poorest in areas such as health and education [18]. Colombia was the exception in this crisis, since it did not have a fiscal imbalance and did not subscribe to adjustment agreements. On the contrary, it continued to grow, being one of the few countries in the region where social spending increased from 7.8% of GDP in 1980 to 8.1% in 1989, without a significant increase in poverty [14,19]. The World Bank's "World Development Report 1993: Investing in Health" [20] proposed three strategies for public policies aimed at improving health conditions in developing countries. The first, based on general social and economic growth policies aimed at reducing poverty and improving the quality of life of the population. In other words, to intervene in the social determinants of disease. The second was to redirect public spending on health towards primary care rather than high complexity care, which would prevent the death of more than nine million children under one year of age. The third was to facilitate the participation of the private sector in health insurance and in the provision of services, to help expand coverage and control costs, which at that time only covered 25% of the population [20].

Health as a Human Right

Health is nowadays considered a human right because of its determining role in the protection of life and human dignity, defined as the right of every person to the enjoyment of the highest attainable standard of physical and mental health [21]. However, most countries in the world, including Colombia, as well as the United Nations itself, incorporate it into economic, social, and cultural rights [22]. Since the 1991 Constitution of Colombia, Article 48 has considered social security in health as an inalienable right of all Colombians [23] and health, through the doctrine built by the Constitutional Court in 2008 [24], as an autonomous fundamental right that refers more to the care of illness. Making the Right to Health a reality requires the development of a series of institutional arrangements, such as a set of norms and operational standards that facilitate its implementation. These include aspects such as ensuring its availability, accessibility, acceptability, quality, participation, non-discrimination, transparency, and accountability. Along with these, there are three other determining factors in this process, such as the recognition that this will be a progressive goal, subject to the availability of resources and, in some cases, dependent on international cooperation.

In addition, it is necessary to adopt health standards that are subject to the constant advances in medicine, which, together with the other requirements, mean that realizing the right to health takes considerable time, sometimes many years. This poses a complex challenge, stemming from the demand for resources, which, in most cases, countries do not have. This is present especially in middle and low-income countries, where international assistance and cooperation play a crucial role in achieving a minimum level of development. For these reasons, health is considered a right of progressive realization, subject to the maximum available resources and to international assistance and cooperation in many cases. In contrast, most Human Rights, such as the Right to Life, Privacy, Prohibition of Torture or Inhuman Treatment, are immediately enforceable. They lack the condition of progressive realization and the other characteristics described for the right to health. These are essential differences between fundamental human rights and the right to health, suggesting that the latter should be approached from a human rights approach rather than being classified as one of them [21,22].

The main failures of the healthcare market

In health care, hospitals behave as natural monopolies, due to the difficulty for them to compete with each other. Professional associations act as monopolies when they want to establish the fee levels. Health insurance companies behave as monopolies when they establish how much to charge doctors and hospitals for their services [25]. Without state regulation, these situations would end up negatively affecting all actors, but especially patients and those who finance the services [26]. The main imperfection of the healthcare market is known as information asymmetry. It consists in the fact that the patient, who buys a service, has much less information about the service he or she is going to receive than the physician and the hospital who sell it. This can mean that the patient ends up consuming more or less than he or she really needs, at prices that do not reflect what a service really costs, or simply receiving what he or she does not require [27].

These limitations are what make it an imperfect market, in which the expected results for sellers and buyers, but especially for the latter, may not generate benefits equivalent to the services received. This is a relationship in which the parties have asymmetric information that

could also favor the patient, who, being ill, may hide his condition and try to enroll in health insurance to cover the cost of his care, which is known as "adverse selection". Insurers protect themselves from this behavior by not covering existing illnesses at the time of enrollment, charging higher rates to those who they assume may be more likely to become ill because of their condition, or simply denying them enrollment [28], a measure known as "risk selection" or "market cream skimming" on the part of the insurer [29]. Another of the implications of the information asymmetry between patient and physician makes the latter the provider of the service and, simultaneously, its purchaser, since it is the physician who finally makes the decision as to what should be done. This is a situation in which a conflict of interests could arise, in where the physician could take advantage of this for himself. One of the forms of this is the induction of demand, that is, recommending more services to the patient than would be necessary, but from which the physician benefits [30,31]. This places the patient in a condition of vulnerability with regard to the physician, which societies have tried to remedy by means of codes of ethics, the Hippocratic [32] being the best known. These are arrangements that seek to impose limits on the physician's work, with the intention of preventing his or her conduct from affecting the patient's health or interests. A third mechanism designed to mitigate the negative effects of information asymmetry is the intermediation of a third-party agent acting on behalf of the patient [31].

This task is carried out by health insurance companies, which originated in response to societies' need for solidarity-based financing mechanisms that would not leave the burden of the cost of services solely on the patient and his family, as happened in Germany at the end of the nineteenth century under the leadership of Chancellor Otto von Bismark [33]. Health insurance became more necessary in the second half of the 20th century, when the advance of medicine and the consequent increase in costs made it impossible for patients to pay for the services they required on their own [34]. The initial health insurance companies then specialized in health as prepaid medicine companies, health promoting entities or health maintenance organizations. These new entities were in charge of paying for the patient, organizing the provision of services, and even intervening in the behavior of the insured to modify their risk of falling ill. These tasks, assumed by the insurers, have been criticized by the medical profession and the hospitals themselves, which they have considered an intrusion in the relationship with their patients, which in their opinion negatively affects the results, especially their quality [35]. There are other market failures that could also affect the expected benefits for the patient and their cost. For example, when the physician is the owner of the services received by the patient, or when he/she uses technologies that are his/her property or from which he/she receives some benefit, which are not cost-effective/efficient, that is, when the result obtained is not proportional to the cost assumed when compared with other available alternatives [36]. To control this, the States have demanded the evaluation of health technologies as a prerequisite to allow their use, and in the other case, they have prohibited the physician from self-referring the patient to services of his property. In addition to the above-mentioned failures of the healthcare market, there is another one caused by the fact that its players prefer to take advantage of not competing with each other, placing obstacles in the way of doing so. This is the case when physicians put up barriers to prevent new competitors from entering their markets, such as when they restrict the training of new specialists, or establish severe requirements for their foreign colleagues to be able to practice their profession. In the same sense, hospitals also do the same, behaving as natural monopolies [37]. This allows them to have higher prices and insufficient services by generating waiting lists. This is facilitated by the relatively small size of the market in certain places, associated with the high investment costs required to set up a new hospital, which makes it difficult to do so [38]. Also, as part of these anti-competitive attitudes, doctors and hospitals artificially create markets with different products and qualities, depending on who pays, so that they end up selling the same services at different prices. A fourth market failure is that healthcare is an easily differentiated product, making it difficult to be compared by a consumer interested in seeking the best, which in turn facilitates price differentiation. As a result of the differentiation of the healthcare product, services can be offered in a fragmented manner by multiple isolated institutions. This means that it is not a comprehensive aggregated product offered by a single integrated set of providers that generate a final health outcome, but rather the sum of fragmented intermediate outcomes [39], where in the end there is no single party responsible for the final effect. This means that the payment made for services is tied more to the amount consumed than to the integral consequences achieved, where the provider's income increases to the extent that there is greater consumption [40], and not to the level of health achieved by the patient [41].

A fifth failure lies in the fact that health has been considered a good related to human dignity, which places it as a responsibility of the State, making it a meritorious human right. This is where contributing to its financing ceases to be a concern of individuals because, even if they do not pay for it, they must receive medical care [42]. Finally, there is moral hazard, a market failure that occurs when the patient, by not paying for services, reduces his awareness of the implications of consuming them unnecessarily and having to assu-

me their costs, which sometimes leads him to act in a manner unconcerned with his own health or leads him to consume services irrationally [43], in which copays or deductibles have been used as a way of control. This shows that market failures in the health services market have practically existed ever since physicians and patients have freely and spontaneously interacted, with the former offering a complex service and the latter paying for it, in which imbalances can be generated in favor or against both. Therefore, they were not created by any authority and, rather, the activities deployed by the States have always been aimed at correcting them rather than deepening them. The failures in the health services market are inherent to the way it is organized and operates; there will always be problems in any market and there will always be something to improve, especially in the health market, which is considered imperfect, with limited resources and infinite expectations.

Institutional design of Colombia's health care system as set forth in Law 100 of 1993

The health model prevailing in Colombia until 1993 could be classified as segmented, in three subsectors: social insurance, private sector and public assistance [44]. This model separated the population into those without and those with the capacity to pay, the latter comprising two subgroups: the first, made up of those working in the formal sector of the economy, covered by social security institutions (22% of the population); and the second, the middle and upper classes not covered by social security, who turned to the private sector through private insurance or direct out-of-pocket payments (4% of the population). Finally, there were the poor and the majority of informal workers (74% of the population), excluded from social security because they were not employed or not formally employed. Their care was mostly provided by public hospitals and also by charitable or lower quality private entities, to which they paid directly for the service [45].

One of the reasons for Colombia's decision to regulate this market was the exhaustion of the system in operation to meet the demands of the population in terms of protection against disease [44]. This was based on a model in which the vast majority of the population had to pay out of pocket, which also considered the services as State assistance, ignoring its character as a human right and its role as a determining factor in economic development and political and social stability. The design implicit in the 1993 reform was based on the principles of social insurance and not commercial insurance, as claimed [25,37], with the aim of regulating an existing market that was already highly imperfect and inequitable [44], segmented according to the population's ability to pay and almost free of controls. The proposed institutional and regulatory arrangements were intended to correct the market failures described above, with the main strategies being to separate, decentralize and specialize the functions of steering, surveillance and control, financing, risk management and service provision, in autonomous entities in charge of each, in order to reduce the conflict of interest between those who produce, those who buy, those who consume and those who regulate. Affiliation would be mandatory with any insurer, which would have to identify and manage the risks of its affiliates, as well as organize and pay the service delivery network, without being able to exercise discriminatory mechanisms to select risks [44].

Discussion

To state that the 1993 health reform in Colombia turned health care into a commodity subject to the rules of demand and offer forgets that this has been a private scenario recognized as atypical and highly imperfect, in which if the laws of the market were allowed to operate freely, imbalances would be produced against patients and those who finance the services. The institutional and regulatory design of Law 100 of 1993 is an unmistakable intervention of the Colombian State to regulate a highly unbalanced market, with the aim of creating a mandatory and universal public insurance, which turned health into a human right, quite the opposite of a commodity. Measures such as controlling the premium for services, the content of benefits, prohibiting the denial of affiliation based on health status or the non-coverage of pre-existing conditions, requiring the creation of service packages and care networks, and controlling the prices of inputs, among other measures, are clear examples that move this law away from what would be a free commercial market and make it better defined as a socially regulated scenario. However, these measures have been questioned by those whose interests, and not necessarily those of patients, have been affected. Doctors and private clinics considered that this system would interfere in the free relationship with the patient and, therefore, in the quality of service. The pharmaceutical and biomedical technology industries considered that controls on the importation of technologies and their prices would affect them. The insurance sector felt that the regulation of benefits and their average premium, as well as the restriction on the selection of members, would jeopardize the viability of their business. At the very root, there was a claim that particular interests would be affected, which could reduce their income, and this has contributed to delegitimize this reform. Therefore, to label the Colombian health model created in 1993 as neoliberal, ignores its progressive historical evolution as a right, from pu-

blic charity assistance to the poorest offered by private entities, through a right only for workers since 1945, to being considered an inalienable right for all citizens as of Law 100 of 1993.

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