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Tensions over what to include and who to cover in the Colombian health system: the citizens' perspective*

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Abstract

Objective: This research aims to explore and understand Colombian citizens' perceptions of health technologies that should be publicly funded.
Methods: We used a qualitative case study approach. Information was collected through semi-structured interviews with 46 citizens in five population groups (citizens without recent contact with the healthcare system, patients, healthcare workers, managers, and decision-makers). Subsequently, we performed a thematic analysis.
Results: We identified two approaches for considering the public funding of health technologies. One approach conditioned the public funding to 1) the characteristics of who needs the care, 2) the disease suffered, 3) the health technology required, and 4) the expectation of efficient performance of the health system. In this approach, coverage is determined by the individual income and economic vulnerability, the urgency of the care or the evidence of effectiveness. The other approach considered that all health technologies must be covered for all Colombians based on principles of human dignity, the right to health and transparent use of public resources.
Conclusions: The approaches identified unveil sociopolitical tensions related to the structure of the health system and its organization in the delivery of services. Three were the most critical tensions: those associated with the ability to pay the citizen, the perspective defining health, and the meanings of effectiveness and scientific evidence.

----------*Keywords:* citizen, policy decision-making, health system, public resources, inclusion, exclusion, perceptions.

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Las tensiones sobre qué incluir y a quién cubrir en el sistema de salud colombiano desde la perspectiva de un grupo de ciudadanos

Resumen

Objetivo: Esta investigación pretende explorar y comprender las percepciones de un grupo de ciudadanos sobre las tecnologías y los servicios en salud que deben financiarse con recursos públicos.
Métodos: Se utilizó un estudio de caso cualitativo. Se recolectó información mediante entrevistas semiestructuradas a 46 participantes en cinco grupos poblacionales (personas sin contacto reciente con servicios de salud, pacientes, trabajadores de la salud, administradores y tomadores de decisiones). Posteriormente, se realizó un análisis temático.
Resultados: Se identificaron dos aproximaciones para llevar a cabo la financiación de tecnologías y servicios en salud con recursos públicos: una aproximación la condiciona a 1) las características de quién necesita la atención, 2) la enfermedad que padece, 3) la tecnología o servicio requerido, y 4) la expectativa de desempeño eficiente del sistema de salud, determinando la cobertura por las condiciones económicas y la vulnerabilidad social de la persona, la urgencia de la atención o la evidencia de efectividad. La otra aproximación considera la cobertura total de las tecnologías y los servicios para todos los colombianos, basada en principios de dignidad humana, derecho a la salud y uso honrado de los recursos.
Conclusiones: Las aproximaciones identificadas responden a tensiones sociales relativas a la estructura del sistema de salud y su organización en la prestación de servicios. Las tres tensiones más importantes son aquellas relacionadas con la capacidad económica del ciudadano, la perspectiva que define el concepto salud-enfermedad, y los significados de efectividad y evidencia científica.

---------*Palabras clave:* acceso a los servicios de salud, financiación gubernamental, necesidades y demandas de servicios de salud, participación ciudadana, sistema de salud

As tensões sobre o que incluir e a quem dar cobertura no sistema de saúde colombiano desde a perspectiva de um grupo de cidadãos

Abstract

Objetivo: Esta pesquisa pretende explorar e compreender as percepções de um grupo de cidadãos sobre as tecnologias e os serviços em saúde que devem ser financiados com recursos públicos.
Metodologia: Foi usado um estudo de caso qualitativo. Coletou-se informação por meio de entrevistas semiestruturadas a 46 participantes em cinco grupos populacionais (pessoas sem contato recente com serviços de saúde, pacientes, trabalhadores da saúde, administradores e tomadores de decisões). Posteriormente, foi realizada uma análise temática.
Resultados: Identificaram-se duas aproximações para fazer o financiamento de tecnologias e serviços em saúde com recursos públicos. Uma aproximação condiciona o financiamento 1) às características de quem precisa a atenção, 2) à doença que padece, 3) a tecnologia ou serviço requerido e 4) à expectativa de desempenho eficiente do sistema de saúde, determinando a cobertura pelas condições econômicas e a vulnerabilidade social da pessoa, a urgência da atenção ou a evidência da efetividade. A outra aproximação considera a cobertura total das tecnologias e os serviços para todos os colombianos, baseada em princípios de dignidade humana, direito à saúde e uso idôneo dos recursos.
Conclusões: As aproximações identificadas respondem a tensões sociais relativas à estrutura do sistema de saúde e sua organização na prestação de serviços. As três tensões mais importantes são aquelas relacionadas com a capacidade econômica do cidadão, a perspectiva que define o conceito saúde-doença e os significados de efetividade e evidência científica

---------*Palavras-chave:* acesso aos serviços de saúde, financiamento governamental, necessidades e demandas de serviços de saúde, participação cidadã, sistema de saúde

Introduction

Citizen participation has been understood as the process by which citizens who are not elected officials become involved in decision-making processes on governmental issues that affect them directly or indirectly. Citizen participation has gained prominence in recent years [1] and has become a priority for health systems [2-4]. Due to the COVID-19 pandemic, citizens have developed a greater interest and willingness to influence health policy decisions [5,6]. However, this increased interest and willingness to act do not ipso facto translate into more meaningful spaces or opportunities for participation.

Decision-makers must commit to citizen participation by identifying the time in the policy cycle at which such participation is desirable, necessary or indispensable, listening to the opinions of those affected by decisions, and incorporating and reflecting those opinions in the final outcomes. Health systems benefit from consolidating participatory spaces and processes by providing citizens with more transparent, legitimate, accountable, acceptable, and credible decisions [7].

In Colombia, despite the recognized benefits of citizen participation, which include public deliberation to settle differences and build agreements, the strengthening of democracy, and confidence in its rules of the game, several authors have pointed out how institutional spaces for citizen participation in health are highly restricted and lack weight in governmental decisions [8-10].

The definition of health priorities, especially when deciding which health technologies to finance with the public budget, is a significant concern for decision-makers, researchers, professionals, and citizens. Colombia is no stranger to this challenge; on the contrary, the progressive recognition of health as a fundamental right drives the health system's interest in ensuring that citizens' voices are reflected in decisions on what should be financed with public resources [11].

In compliance with the mandate of the Constitutional Court, Law 1751 of 2015 [12] delegated to the Ministry of Health the establishment of a technical-scientific and participatory procedure to determine the technologies and services that will be excluded from public funding; this law was implemented through Resolution 330 of 2017 [13]. Despite the progress made by both the Ministry of Health and the Institute for Health Technology Assessment to incorporate the values and preferences of citizens in decisions, there is skepticism among decision-makers about the ability of an informed citizen to participate and contribute to the task of defining exclusions and priorities in health [14].

In Colombia, the establishment of health priorities is even more complex due to factors such as the distrust exhibited by stakeholders about the legitimacy of participatory spaces and their participants, the lack of knowledge about the perceptions of Colombians regarding the technologies and services that should be financed with public resources and, finally, because of the prejudice that exists about the capacity of the ordinary citizen to put collective well-being before individual interest [15].

Despite the challenges, scholars in the health systems field have identified that using scientific evidence improves the political decision-making process [16] and enriches citizen participation [17]. It has been recognized the importance of proposing, developing, and evaluating mechanisms that support the use of scientific evidence by decision-makers and stakeholders as a strategy to strengthen health systems [18,19]. Evidence transcends the simple use of information on the effectiveness of medical interventions. It encompasses broader questions about how to organize health systems to ensure that interventions reach those who need them in socially and culturally acceptable ways.

In this context of gaps and challenges, this research explores and understands some citizens' perceptions about which health technologies should be paid for with public resources.

Methods

This qualitative study used semi-structured interviews conducted with different citizens: plain citizens without recent contact with health services, patients, health professionals, health managers and decision-makers, which were transcribed, coded and analyzed by the research team from a constructivist paradigm to explore the perceptions of these different groups of Colombian participants about the health technologies that should be publicly funded.

Design

We used an embedded single-case study methodology [20], in which several subunits of analysis called "embedded units" were incorporated into a case, offering opportunities for a more extensive analysis. In this research, this design allows for an internal analysis of the views of each group of participants separately and their comparison with each other.

The context for this study was the Colombian health system and its regulations, financing and funding arrangements, infrastructure, human resources, delivery model, and mechanisms for defining the health technologies covered.

The case was limited to Colombians' perceptions about the health technologies that should be publicly funded.

The embedded units were the groups of participants with different interests, knowledge and values regarding the health system.

Participants

Purposive sampling was applied to ensure a plurality in selecting participants, mainly in terms of age, geographic representation, and gender [21].

The participants were classified into five groups according to their relationship to the health system, experience, and perspective. Four to eight participants per group were planned, for 20 to 40 participants included in the study or until saturation of the sample was reached.

The first group consisted of plain citizens who have not had recent contact with health services (have not been patients or caregivers of patients in the last 12 months), were not healthcare professionals, managers or decision-makers, nor have a family relationship with any of them (up to the second degree of consanguinity). The second group consisted of patients with chronic diseases and those who had recently used healthcare services. The third group comprised health professionals actively working in different healthcare settings. The fourth group consisted of people with experience in public or private healthcare management in the last five years. The last group consisted of people in charge of decision-making in public institutions at the national, regional (i.e. departmental), or municipal level or with functions of contracting services and establishing healthcare networks in insurance companies that administer public insurance.

The research team nominated candidates to participate in the study. Those candidates were contacted by phone, in person, or e-mail using a pre-established invitation message.

Interview guide and procedure

The research team developed a semi-structured interview guide with two sections: in the first, three open-ended questions were asked, inquiring about the general opinion on technologies and health services that should or should not be publicly funded and the experience of paying for them in a particular way. In the second section, four cases were presented that represented controversial situations in deciding whether to cover certain health technologies, in which it was anticipated that opinions could vary widely. This selection was made based on cases widely covered by the media.

The interview guide was refined after being applied in a pilot test; the final version is attached in the Appendix and was used in all the interviews after the participant signed an informed consent and authorization to record.

A research team member transcribed the interviews and reviewed them for accuracy. The transcribed texts were anonymized and stored digitally for later analysis.

Data analysis

The research team developed a codebook used as seed categories to analyze the interviews. Two interviews were pilot-tested using open coding, which refined the codebook and helped the team to agree on how to use it. The final list of codes consisted of opinions on whether various health technologies should be publicly funded and the rationale for these opinions.

Pairs of research team members open-coded the transcribed interviews. The information was analyzed according to the participants' group (embedded units) in multiple team meetings until each group's correlation categories and similarities and differences were defined. Several analytical memos were developed to document initial impressions of the emerging themes and their relationships.

An axial coding process was employed, establishing categories that interconnected the themes, opinions, and justifications related to considerations for including technologies and services to be publicly funded [21,22].

The ATLAS.tiTM 6.2 program was used to facilitate open and axial coding.

Reflexivity

The research team discussed their experiences, opinions and knowledge about the health system and the health technologies that should be publicly funded.

To prevent the researchers' perceptions from influencing the way the results were analyzed or presented, the group corroborated that the emerging categories and connections between themes did indeed emerge from the analysis of the interviews and that all the points of view identified in the interviews were represented in the categories and findings to be reported.

Ethics

This study was approved by the Faculty of Medicine Ethics Committee of the University of Antioquia in Minute 009 on May 9, 2019. The research team embraced all research ethics recommendations, ensuring that participants recognized their rights, which include the right to withdraw at any time from the study, confidentiality, and that the study did not represent a risk to their life or good name.

Results

The results of this research are presented below. Initially, a descriptive analysis of the population is made. Subsequently, the perceptions of the five groups of participants are analyzed separately. Finally, categories of public funding for health technologies are correlated.

Description of participants

The final sample included 46 people aged between 23 and 66 (mean = 39; standard deviation = 11), of whom 57 % were women. Of the 46 participants, five belonged to the patient group, five to the healthcare manager group, five to the decision-makers group, 13 to the health professionals' group, and 18 to the plain citizen group. The characteristics of the interviewees are summarized in Table 1.

In the group of patients, we interviewed people from three departments -Antioquia, Santander, Meta-, affiliated to both the subsidized and payroll contribution regimes, with various conditions that required outpatient healthcare, surgery, hospitalization and rehabilitation services. One participant was the caregiver of a child who required recent medical attention. The healthcare professionals group included doctors, nurses, dentists, social workers, and surgical instrumentation professionals who worked in public and private institutions in outpatient, inpatient, and surgical services. All the healthcare managers were residents of the department of Antioquia -specifically of the municipalities of Rionegro, Ebéjico, Medellín and Mutatá-, working with healthcare institutions and local/regional health agencies. There were two decision-makers whose scope of decision was regional -only Antioquia- and three whose scope was national. Some decision-makers worked for private insurance companies, and others for the government (both executive and judicial branches).

In the plain citizen group, we interviewed residents of two departments -Antioquia and Caldas- and the district of Bogota. Participants resided in urban and rural areas and had different socioeconomic backgrounds. According to their affiliation to the health system, three participants were affiliated to the subsidized regime, 14 to the payroll contributions regime, and one to the special regime. The educational level of the interviewees in this group ranged from high school to graduate. Eight reported having children, and five reported belonging to a citizens' organization.

Arguments for defining whether to fund technologies and services publicly

Participants considered different reasons to justify when a health technology should or should not be publicly funded (see Figure 1 and Table 2). One perspective was to include everything without any population or technology/service prioritization criteria. Arguments were based on precepts of human dignity, which calls for coverage of all health technologies required by each person to materialize and achieve individual human dignity. The second argument was based on the entitlement derived from making payroll contributions, which grants the contributor and their beneficiaries the right to receive all the health technologies required. The latter argument justifies full coverage as a response and alternative to the distrust in the management of public resources in the health system; in this case, citizens put access to all health technologies before the risk of misappropriation of health resources due to corruption or inappropriate management.

In addition to views on full coverage and coverage for all, we identified four domains of arguments that subordinate public funding of health technologies, named characteristics of the person, disease, health technology, and expectations of efficient system performance.

Characteristics of the individual

In the first domain, coverage is conditioned to the characteristics of the person receiving healthcare, particularly concerning the level of need for care; the impact on quality of life, psychosocial well-being or limitation to their human dignity; vulnerability factors, for example, considering age -prioritizing children and the elderly-; geographic residence, ethnicity and socioeconomic status -ability to pay-, as reflected in the following excerpt from one of the interviewees:

> If it's a billionaire, no. I cannot allocate health resources to give free treatment to that kind of person if they can pay [Woman group 1].

In this domain, citizens from different population groups commonly invoke equity and social justice arguments that prioritize whom citizens receive health care according to their needs, seeking to achieve horizontal and vertical equity.

Disease characteristics

In the second domain, coverage is conditioned to the characteristics of the disease or condition of the person requiring the health technology. This means that, for some participants, certain types of diseases, such as cardiovascular diseases, legitimize public funding, while other diseases or conditions, such as those affecting mental health, rare or orphan diseases, or those whose treatment is labelled as "cosmetic," do not qualify as deserving public funding.

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Table 1. Characteristics of participants by population group

Characteristic		Plain citizens (N = 18)		Patients (N = 5)		Healthcare professionals (N = 13)		Managers (N = 5)		Decision-makers (N = 5)	
Age range		29-66		25-59		23-57		31-46		37-55	
Women		n	%	n	%	n	%	n	%	n	%
		11	61,1	4	80,0	7	53,8	2	40,0	2	40,0
		n	%	n	%	n	%	n	%	n	%
Municipality of residence	Bello	1	5,6	1	20,0	-	-	-	-	-	-
	Bogotá	3	16,7	-	-	2	15,4	-	-	-	-
	Bucaramanga	-	-	1	20,0	4	30,8	-	-	-	-
	Ebéjico	2	11,1	-	-	-	-	1	20,0	-	-
	Envigado	1	5,6	-	-	-	-	-	-	-	-
	Manizales	1	5,6	-	-	-	-	-	-	-	-
	Marinilla	-	-	-	-	-	-	-	-	1	20,0
	Medellín	8	44,4	2	40,0	6	46,2	1	20,0	4	80,0
	Mutatá	-	-	-	-	-	-	1	20,0	-	-
	Rionegro	-	-	-	-	-	-	2	40,0	-	-
	San Jerónimo	2	11,1	-	-	-	-	-	-	-	-
	Villavicencio	-		1	20,0	-	-	-	-	-	-
	Yolombó	-	-	-	-	1	7,7	-	-	-	-
Type of affiliation to the health system	Subsidized	3	16,7	2	40,0	-	-	-	-	-	-
	Payroll contribution	14	77,8	3	60,0	13	100,0	5	100,0	5	100,0
	Special	1	5,5	0	0	-	-	-	-	-	-
Has additional private health insurance	Yes	3	16,7	1	20	2	15,4	2	40	1	20
	No	15	83,3	4	80	11	84,6	3	60	4	80

Characteristic		Plain citizens (N = 18)		Patients (N = 5)			Healthcare professionals (N = 13)			Managers (N = 5)			Decision-makers (N = 5)		
Specific variables by population group	Area of residence	n	%	Healthcare setting	n	%	Field	n	%	Healthcare institution managed	n	%	Scope of the decision-making	n	%
	Urban	14	77,8	Hospital	1	20,0	Public	7	53,8	Healthcare institution	3	60,0	Local	2	40,0
	Rural	4	22,2	Outpatient	4	80,0	Private	6	46,2	Local or Regional health agency	2	40,0	National	3	60,0
	Socioeconomic status	**n**	**%**	**Condition**	**n**	**%**	**Healthcare setting**	**n**	**%**	-	-	-	**Institution**	**n**	**%**
	Very low	3	16,7	Infectious disease	1	20,0	Medical consultation	5	38,5	-	-	-	Private	3	60,0
	Low	3	16,7	Chronic disease	1	20,0	Hospitalization	3	23,1	-	-	-	Public	2	40,0
	Medium-low	3	16,7	Traffic accident	1	20,0	Emergency department	4	30,8						
	Medium	7	38,9	Paediatric care	1	20,0	Rehabilitation center	1	7,7						
	Medium-high	2	11,1	Cancer	1	20,0									
	Educational level	**n**	**%**												
	High school	3	16,7												
	Technical	3	16,7												
	Professional	6	33,3												
	Graduate	6	33,3												
	Have children?														
	Yes	8	44,4												
	¿Is affiliated to a citizen organization?	**n**	**%**												
	Yes	5	27,8												

* This information it was collected for all participants

Figure 1. Arguments for public funding of health technologies.

Source: Own construction, based on the results of this research.

It was also mentioned that health promotion and disease prevention activities aimed at the entire population, or large groups within it, should be privileged.

> I don't know to what extent [they] can spend an entire national health system covering these occasional sporadic and rare diseases, subjecting and taking resources away from a majority population [Male group 3].

Technology or service characteristics

In the third domain, coverage is conditioned to the characteristics of the health technology demanded. This domain includes a large part of the exclusion criteria used by the Constitutional Court in Law 1751 of 2015 [12]. For example, participants mentioned that health technologies provided abroad, for cosmetic purposes and in experimental phases, should be paid for privately and not publicly funded.

Some citizens from the various groups mentioned that expensive technologies and services classified as "alternative medicines" or considered complementary to the health benefit plan, such as personal hygienic supplies, should also be excluded from payment with public resources.

> Aspects that are sumptuous, experimental, and done outside the country [...] should not be recognized. We have many patients who ask us for treatments abroad when they do not have scientific evidence but are experimental in Boston or Houston. It works for some patients, and we end up paying for them when it should not be that way [Male group 5].

In domains two and three (characteristics of the disease and characteristics of the technology), we identified that participants used reasoning that coincides with a utilitarian approach to social justice, in which aggregate welfare is maximized and it is assumed that health

Table 2. Arguments for coverage of health technologies and services with public resources expressed by the participant groups

Argument	Group 1	Group 2	Group 3	Group 4	Group 5
Constitutional obligation	"It's that... in an ideal State, right? Everything should be covered in the State that was invented in the 19th century and at the beginning of the 20th century, but it turns out that there are too many of us, we are already too many, and well... it is a little more complex... but why? Because, in theory, that state must guarantee a welfare state, and that welfare state also implies the health of its citizens."	"I would think that not only the exams; I would think that everything related to life, to health, should be... should be the government's responsibility, that everything should be paid for so that you are in a good state of health."	"Because we are in a social rule of law, where health is a fundamental right for all Colombians, regardless of our age, social class, academic level, simply because it is an inalienable right that we have, and it is the right to health." "I see health as a right just like education; the state should provide you with all that. It is a very paternalistic vision; they should not charge you for education because you will pay for all that later".	"If we base our rationale on the right to life and health, then this implies that regardless of the cost, what they are guaranteeing is a right, and this right cannot be quantified; it is a right. So, I think that regardless of the cost, it should be covered if it is going to guarantee quality of life and improve the health status."	"Because it is not my fault that my disease requires a more expensive treatment than that of others. Finally, it is the right to health, which has, consequently, the right to life. They should not have to limit me, knowing that I need it. I believe that it is the duty of the State to provide me with the mechanisms that I require to guarantee my right to health." "Well, everything that covers diseases: both diseases and prevention, because health is primordial; in fact, it is a constitutional right, and we need the State to guarantee it."
Entitled given payroll contributions	"I think everything should be [covered]. Man! I am contributing with a family group; my family group should be entitled to everything just like me because I am a contributor." "So, sometimes you lose treatments because you can't buy them. And you say: 'Man, I'm paying payroll contributions for health, and I don't have the right to this treatment because the benefits plan does not cover it! It seems to me that, knowing that you are making payroll contributions, you should be covered! No one chooses to get sick, but your treatment should be covered.	"What happens is that in the towns some people say: 'Oh, the State gives me'. And I say: 'No, the State does not give you; we taxpayers pay for that because we contribute.'... so, I am more of a paternalist; I would say that the State should cover everything." "Well, the truth is, I think that all of them, eh, why? Because at least we, when we are employees, they make us pay, let's say in a certain way, for healthcare; so, we are already contributing, apart from the taxes we pay, out of the services, and those are resources that are also destined to the Government. Well, I think they should cover everything that affects our health".		"I think that in the case of healthcare services, being a fundamental right, should not differentiate between diseases or pathologies, medicines or not, ability to pay or not; therefore, there is a circulatory system of resources where there are also contributions from the State, from the taxpayers who pay and subsidize to another group of people, so we have a positive and well-done economic dynamic".	

Rev. Fac. Nac. Salud Pública -DOI: https://doi.org/10.17533/udea.rfnsp.e356278

Argument	Group 1	Group 2	Group 3	Group 4	Group 5
	"Yes, because we are permanently making contributions to the health system, and I think it is equitable and fair that by making those contributions month after month for decades, the State should take care of it."				
Corruption of the health system	"Yes, that's what the health system is for, right? Not only for the government to steal the money but to be invested in what it is, in health. It is like the universities, where the budget is less and less because they invest it in other things that, in the end, are irrelevant. After all, as I was saying, they simply steal it, they don't invest it, it goes to the pockets of a few and that's it." "Because you can say 'no, I need diapers,' and that same person can arrive, take them and go and sell them; then, it is necessary to know if you need them." "I think that the same system, in the part of corruption, treats health as if it were a business, as if it wanted to provide the most basic services with the cheapest medicines and technologies, both in tests and medicines and even placing obstacles to be able to be attended by the specialists that people really need. So, in order to access a specialist, you have to visit a general practitioner countless times when you have		"I think there is a bad intention on the part of the insurance companies. That person needed to have that procedure done within his benefits plan; therefore, there should not have been a barrier to access to the service... In other words, what the insurance company did was generate an administrative barrier to access to health services. This should not only be rejected but punished".		

Argument	Group 1	Group 2	Group 3	Group 4	Group 5
	already done so. So, I think this system of corruption and access to technologies has been permeated against the user and all the people of Colombia".				
Characteristics of the person	"If it is a billionaire person, no. I cannot allocate health resources to give free treatment to that kind of people if they can pay". "All because there are people who do not have resources to pay; if sometimes it is difficult for them to pay a co-payment of $1 dollar, now a test, or drug... I would think that the health system should cover everything for people like this."	"I understand that it is cosmetic, but it is not for everyone; for some people, it is a saviour" ... 'Because possibly the trauma that a woman has suffered after having lost something as feminine as her breasts, then it seems to me that it should be covered." "As I tell you, the most serious things should be included in the system, for example, for children and people with cancer. I believe that medicines and everything should be included in the health system for them".	"Yes, because there is a connotation that is linked to the issue of identity as a woman, and in this case, let's say that breasts are not only seen from the point of view of the functionality that a woman may have but also in their identity element and how they see themselves, your condition as a woman. It is not only a matter of taste because there is a pathology, and it has altered the perception of this person in her condition as a woman. In this case, it is necessary, and she needs it; of course she does." "If I have a problem that solves it or corrects it, the plastic surgeon and psychologically is creating a problem in me, not only physically, but mentally. That should also be within the healthcare services I am entitled to."	"That is an ethical problem, and it was like the one I was telling you about [name of the insurance company]; and that is to transfer all that money to two people, and look, I am a priest. We would have to ask ourselves: what levels of quality of life are being achieved from that treatment?" "When you specifically ask me not to include beauty, the image of Natalia Ponce de León comes to my mind, the girl who was disfigured by her couple... then, one says: all this reconstructive surgery, what are they looking for... beauty?"	"It [depends] on the age as well, because it is not the same to invest in a young person who has a better chance of survival than in a senior citizen."

Rev. Fac. Nac. Salud Pública -DOI: https://doi.org/10.17533/udea.rfnsp.e356278

Argument	Group 1	Group 2	Group 3	Group 4	Group 5
Characteristics of the disease	"Because it's one thing to change gender, and hormone treatment is fine, but then they want liposculpture, liposuction, to have their breasts done, removed, etc."	"Very complex and understanding the defence of transgender people and all these people with disorders and gender identity issues. We not only have to change the defects, but then we must beautify them, and that's where I don't like it because apart from changing their gender, we have to make them beautiful. That's where I think the system is abused".	"Listen to me well because I don't want to be biased; as a physician, it would be ideal if everything were covered, but in a country like ours, where more people die from malnutrition, where more people die from cancer -this is still one of the biggest causes of mortality-, these occasional sporadic and very rare diseases, I don't know to what extent [they] can consume an entire national health system, in the coverage of these types of diseases, subjecting and taking resources from a majority population" "Depending on the number of cases and patients, it could be conditioned to this, so that the high-cost ones would be covered for more frequent diseases in the population than for rarer diseases"	"My idea has always been opportunity cost. I would go for more general affectations, not so specific."	"An augmentation mammoplasty in patients with gender dysphoria, in this case transfeminine, I consider that a principle of comprehensiveness should cover it in a health condition, which is the patient who feels she is a woman and who already has that comprehensive approach because it is not delivering a technology for the sake of delivering it, because there are insurance companies that if they get a court ruling, then [they say]: 'Let's give her breasts'; who also wants buttocks: 'Then let's give her buttocks.' No!"

Argument	Group 1	Group 2	Group 3	Group 4	Group 5
			"But if it is a girl who has very large breasts that are causing her back and shoulder problems, why can't it be done with public resources if she already has a physical and mental problem?"		
Characteristics of the technology or service	"If they have the scientific backing, they should be covered. But what I am telling you: with the scientific backing, not what the herbalist on the corner said, that will work for him." "Those types of operations, I can't imagine that they should be publicly funded because you don't really have a disease, you didn't go through a medical process or a debilitating disease such as cancer or chemotherapy, which can kill your hair and have many effects on the body, to come and say that you are not happy with a part of your body or 'I'm bored and I'm going to have an implant,' or 'I don't like the fat I have, I'm going to have liposuction'."	"For example, many aesthetics surgeries are for vanity, but if you really need it, the insurance company should pay for it; although if it is for vanity, I don't think so."	"There is already a 'battery' of therapeutic options for diseases, things that are recommended by the medical community, and that is what should be publicly funded by the health system... so, I believe that these alternative therapies should not be covered, because what is covered should be what is indicated within the recommendations of doctors."	"No... whatever are experimental issues... I think the benefits plan should not cover them. Of course, when we are in research stages [...], we are still in high margins of trial and error, which will not guarantee patient safety."	"The only thing that I would say should not be publicly funded by the health system, that is scientifically and medically proven, is everything that is aesthetic interventions that are motivated by an improvement of the image and not by a pre-existence or a basic clinical condition." "Sumptuary aspects, of an experimental nature, and done abroad, those criteria should not have recognition. Many patients ask us for treatments abroad when they do not have scientific evidence; they are experimental in Boston or Houston; it works in some patients, and we end up paying for them when it should not be that way."

Rev. Fac. Nac. Salud Pública -DOI: https://doi.org/10.17533/udea.rfnsp.e356278

Argument	Group 1	Group 2	Group 3	Group 4	Group 5
Expectations of efficient health system performance	"Well, recently, I read the news of a child who needed an experimental treatment, and the treatment was in the United States, that is, a treatment in thousands of dollars. On the one hand, the cost is high; on the other hand, it is an experimental treatment, and the results may not be what people expect. Considering that resources are always limited, I believe that it is hard to say it on some occasions, but this type of treatment cannot be covered. I know that we are talking about a human being and the suffering and all that, but knowing that with that same money, one can use it to treat other types of diseases with proven effective treatments, I would go, well, that way." "Things must also have a limit, and again, going back to the issue that it is a system with limited resources, you have to use them most efficiently, and sometimes that implies assessing a risk of doing or not doing a treatment."	"Sincerely, that is already completely out of the question.... I say, [to cover] those that one knows are for normal diseases, for certain treatments that may occur, that seems perfect to me; but for the most expensive things that one does not know if they are going to be useful or not, but they do cost a lot of money, it seems to me that they should not"	"If it has evidence, and it is similar to another and has a better price, it can be given. But if there are other things that are cheaper and it has equal or superior effectiveness, there would be no indication to resort to this specific type of example."	"On one occasion a user with leukemia arrived, and it turns out that, doing the budget calculations, a single person would spend the entire budget of the department of Chocó on healthcare. Then, the ethical conflict arises: do we treat this person with leukemia, or do we treat the rest of the population affiliated to that system? Therefore, it seems to me that this should be closely scrutinized and handled with supreme discretion, where health conditions are guaranteed." "So, artificial insemination is not the fact of performing the insemination, but the controls and the possible losses you can have later. In other words, we do not know how the cascade will continue and what resources it will consume from the State, and these are not infinite; they are in a budget and must be made to yield. I, who has been a manager, have seen this difficulty of allocating resources for something that will not come up."	"In the medical and economic literature on health, there are many analyses on waste in health, and many prescribed technologies sometimes are not generating benefits for the patient, but rather adverse effects or maleficence as such, and waste of technologies that patients do not really require." "Regardless of the price, as long as they have a study that is proven and prescribed by the doctor that it is going to work and that it has probabilities, I do believe that it has to be covered by the system, regardless of the value of the same" "For me, what determines whether a health service should or should not be included would be technical-scientific criteria. And there is a discussion of the weaknesses of science, which is not an irresolute or infallible source either; but, precisely, that scientific thinking, that methodical doubt, is what allows us to rethink concepts constantly, verify what is being done and change what is susceptible to improvement"

Argument	Group 1	Group 2	Group 3	Group 4	Group 5
				"It does put me in a dilemma. I think not, because not all of them bring the improvement they should bring. If all expensive treatments gave very good results, I would say yes, but since they do not all guarantee success or a sustainable or relevant improvement, I consider that they should not all be authorized."	"The system should fund what is effective and not what is not. The problem is that neither concept is categorical, nor is there a clear objective dichotomy on how I classify something and whether it is effective or not. It moves more within a spectrum of effectiveness."

EPS: Health Promotion Company; IPS: Health Provider Institution; PBS: Health Benefits Plan; POS: Mandatory Health Plan.

system resources should be invested in specific health technologies or diseases that generate a greater net benefit for society. In this sense, covering treatments for prevalent chronic diseases with public resources generates more utility than covering mental health care or care required by people with rare diseases.

> I say, [to cover] those that one knows are for typical diseases, for specific treatments that can be presented to us, that seems perfect to me; but for the most expensive thing and that one does not know if they are going to be useful or not, but they do cost a lot of money, it seems to me that they should not [Woman group 2].

Expectations of efficient system performance

In the last domain, we collected arguments about efficient system performance expectations. Within this domain, we highlighted four premises that were used as criteria to define the public funding or not of health technologies: 1) the existence of scientific evidence, which for practical purposes implies that in its absence, it is not publicly funded, and that in its presence it passes to a phase of reflection on its coverage; 2) the demonstration of effectiveness and benefit of the health technology required; in this case, which accredits benefit and safety would be covered; 3) proof of a favourable cost-benefit ratio, which subjects the exclusion of the health technology to which reasonably exhibits a very high cost for a very small benefit; and 4) confirmation that it is a health technology explicitly recommended by the medical-scientific body for use in the patient's condition.

> If it has evidence, is similar to another, and has a better price, it can be given. But if there are other things that are cheaper and have equal or superior effectiveness, there would be no indication to resort to this specific type of example [Man group 3].

Additionally, we identified two other arguments that refer, on the one hand, to the need to prioritize and ration health spending, recognizing the scarcity of public resources in the health system, and, on the other hand, to the constitutional obligation to guarantee and make prevail in every decision the rights to health, life and human dignity.

> So, artificial insemination is not the fact of performing the insemination but the controls and the possible losses you may have later. In other words, we do not know how the cascade will continue and what resources will be consumed by the State, and these are not infinite; they are in a budget and must be made to yield. As a manager, I have seen the difficulty of allocating resources for something that will not come up [Male group 4].

We identified some tensions influencing Colombians' perceptions about which health technologies should be publicly funded and when. The three most essential tensions refer to: 1) the use of criteria based on the ability to pay of the citizen -and not on their health needs- to determine the public funding; 2) the perspective adopted to define what is health/disease and, therefore, the tension that emerges between diseases and conditions considered "legitimate" and those that are not; and 3) the ambiguity or specificity that the concepts of effectiveness and scientific evidence may have.

The first tension identified among several plain citizens, patients and managers was to consider a person's ability to pay as a criterion for defining the coverage of a health technology required. Under this argument, the ability to pay qualifies and accredits citizens as deserving of publicly funded healthcare, not their medical needs [23]. In the interviewees' words, it is equivalent to the criterion of "covering the poor and charging the rich".

The second tension is linked to the participants' definition of health and disease. Some interviewees judged that there are "legitimate" diseases or conditions that merit public funding for their treatment. For example, they readily acknowledged the legitimacy of covering prevalent conditions, physical illnesses, and those requiring health technologies aimed to improve functionality. Still, there were discrepancies when reference was made to mental, rare or orphan diseases or conditions in which treatments are intended to improve self-esteem or quality of life. One interviewee commented as follows:

> When you specifically ask me not to include beauty, the image of Natalia Ponce de León comes to mind, the girl who was disfigured by her couple... then one says: all this reconstructive surgery, what are you looking for... beauty? [Woman group 3].

The third tension is using arguments about effectiveness to decide whether to fund a health technology publicly. This refers to concepts such as *evidence* or *effectiveness* that are not free of interpretation or value-laden.

Discussion

Through the interviews, we identified two fundamental approaches to consider which health technologies should be publicly funded (Table 3 describes them according to population groups). In one approach, coverage is conditioned on the inherent characteristics of the person needing healthcare, the disease they suffer, the health technologies required, or the expectations of efficient health system performance. The other argues for full coverage of all health technologies required by all Colombians, using axioms related to human dignity, the fundamental right to health, and the honest and legitimate use of resources.

Table 3. Correlation matrix of the determinants of public funding of health technologies identified by the different population groups.

Arguments in favor of public funding		Health technology					
	Hygiene supplies	Alternative medicine	Expensive/ high cost	Experimental	Abroad	Aesthetic	Full coverage
Person	Quality of life/ Human dignity	Cover	NR	Cover	NR	Cover	Cover everything aimed at human dignity
	Ability to pay	Do not cover those with the ability to pay	NR				Cover to all people without the ability to pay
	Need	Cover			Do not cover	NR	Cover everything that people need
	Vulnerability	Cover to the elderly	NR				Cover everything to children and pregnant women
Disease	Type of disease	NR					Cover everything in chronic diseases
	Prevalence	NR		Do not cover rare diseases	NR		Cover everything for highly prevalent diseases
	Aesthetic	NR				Do not cover it if it is only for cosmetic purposes	NR
Health system	Evidence	NR	Do not cover it if it does not have supporting evidence	Cover if has supporting evidence	NR		
	Effectiveness	NR	Cover if it is effective / Do not cover if it is ineffective	NR		Cover	Cover everything effective
	Recommended	NR		Cover	NR		Cover everything that a doctor recommends
	Cost-benefit				NR		
	Scarce resources	Do not cover		NR	Do not cover	NR	
General	Constitutional obligation	NR		Cover	NR		Cover everything because it is a right
	Entitled given payroll contributions				NR		
	Better than corruption	Do not cover		NR			Covering everything because it is a better alternative than leaving it exposed to corruption

NR = No response

We also identified three tensions influencing Colombians' perceptions of which health technologies should be publicly funded and when. The first tension refers to using criteria based on the citizen's ability to pay -and not on their health needs- to determine the public funding of their healthcare. Although, at first glance, it seems to be a criterion of equity or social justice, the truth is that these criteria are neither simple to use nor free of bias and inequity. The line that marks who is rich and who is poor is not easy to delimit and imposes a particular difficulty when distinguishing who is at the center of that dichotomy, i.e., someone from the middle class with no ability to pay. For example, does a family who owns a house and is classified as low socioeconomic status have, per se, less ability to pay than a family that rents a home located in a neighbourhood classified in a socioeconomic status medium? Does a person with three minimum income salaries and four dependents have, per se, less ability to pay than a person with one minimum income salary and no dependents? Deriving these questions to the healthcare system, the doctor, the hospital, or the judge ruling on a Tutela would seem too heavy a burden and have a high risk of bias.

The preference given to the ability to pay as a criterion for access to publicly funded healthcare contradicts a fundamental value of health systems: organizing care and attention according to the degree of need for care. These two perspectives, which are substantially different, demand a broad discussion in Colombian society, mainly because the Colombian system is financed by public taxes that are paid in proportion to the level of salary income. The essence of this system assumes that citizens, when they are healthy and active at work, contribute to the system's financing according to their ability to pay. Therefore, it does not seem rational that when the citizen is sick, the health system judges them, according to their wealth, as undeserving of the healthcare they helped to finance.

The matter is even more complex if one accepts that the principle of medical necessity is the one that should prevail in determining access to health technologies publicly funded. Then, no citizen could be excluded because of their ability to pay, but neither would it be equitable for someone to demand more outstanding healthcare or preferential care by their wealth or ability to pay. Different authors have suggested that "need" is a more legitimate distributive principle than others, such as "ability to pay," because it is clinically relevant and morally defensible [24]. However, it is still a matter of debate how to conceptualize and classify people's needs [24-26]. Academics dedicated to the study of welfare systems have also highlighted that there is a contradiction in health systems: that of putting in the same dimension the values of universality and targeting when these represent opposite dimensions of welfare states, being more useful to understand the opposite of universalism as "residualism", and targeting as a "pro-poor" residualism [27-30].

The second tension identified was linked to the participants' definition of health and disease. Some interviewees judged that there are "legitimate" diseases or conditions that deserve public funding for their treatment. This tension was most evident with the public funding of health technologies needed to treat people with diseases or conditions that require aesthetic treatment. It seems that the boundaries between the purpose of the intervention and the type of technologies and services required are blurred. The fact that the procedure required is plastic surgery does not resolve per se the question of the need and purpose of the surgery; the same procedure may be offered to someone who needs it or to someone who wants it; for one person, it may have a reconstructive purpose or be aimed at improving quality of life, while for another it may be a way of achieving an ideal of personal beauty. Discerning between the purposes is not always obvious. It introduces a gray area where agreed rules could be established to decide in each particular case but integrated into the daily routine of healthcare in Colombia with the perspective of guaranteeing the principle of human dignity.

The third tension was associated with using arguments of effectiveness to decide whether to fund a health technology publicly. As other authors have pointed out, it is not always possible to demarcate a line that differentiates between effectiveness and non-effectiveness.

Strengths and limitations

A great strength of this research is to have gathered the perspectives of people with different profiles and levels of contact with the health system involved in medical, managerial, or political decision-making. Understanding that citizens' positions are influenced by their own experience and knowledge of diseases and health systems, we sought to have these opinions represented in the results of this research.

One limitation of the study was to consider that the five groups of citizens would behave homogeneously within themselves and, therefore, to underestimate the diversity of positions that would emerge in the groups of health professionals and plain citizens, primarily related to their political or ideological position, which we did not ask about in this study. To address the diversity of opinions that emerged during the interviews in these two groups, it was decided to increase the number of interviewees until thematic saturation was achieved, making the number of participants in these two subgroups higher than in the categories of patients, managers and decision-makers. The researchers believe that this stra-

tegy strengthened the research's analyses, results and conclusions.

Implications for the health policy field

The findings of this study have implications for decision-making within the Colombian health system, as they contribute to knowledge about Colombians' preferences and perceptions about how to prioritize health spending and what values motivate acceptance and support for decisions that seek to organize and prioritize the provision of health services in the country.

The identified tensions reveal the difficulty in achieving consensus on what principles should guide resource prioritization decisions. For this reason, some researchers suggest that decision-makers should ensure a fair and transparent process for making these decisions. For example, the "accountability for reasonableness" framework (known as A4R)[33] proposes four criteria that these processes should have: 1) accountability and disclosure: resource allocation decisions and the reasons behind them should be transparent and public; 2) relevance: the reasons underlying the decisions must be supported by relevant evidence; 3) review and appeal: the procedure must allow for review and appeal of decisions by different actors in the system; and 4) regulation and enforcement: there must be mechanisms to ensure that the above three criteria are met [34,35].

Additionally, our findings motivate future research on citizen participation and opinion, on the actual state of citizen participation in Colombia, and on more empirical approaches that aim to evaluate the degree of generalization of our results in the Colombian population and whether these perceptions differ from those of other citizens in health systems in other countries, with different forms of financing or in diverse political and social contexts.

Conclusions

Citizens are very concerned about the definition of health priorities, especially deciding which health technologies to publicly fund. In Colombia, the progressive recognition of health as a fundamental right has promoted the health system's interest in reflecting citizens' opinions in decisions about what will be publicly funded.

In this research, we found that Colombians have different perceptions about the criteria that should be used to define what should be publicly funded. Some of these respond to social tensions related to the structure of the Colombian health system and how the provision of health services has been organized. The three most essential tensions refer to the use of criteria on the ability to pay of citizens to determine their coverage for healthcare with public resources, the perception adopted to define what is health/disease and, therefore, what disease is "legitimate" to be covered with public resources and, finally, the ambiguity or specificity that the concepts of *effectiveness* and *scientific evidence* may have.

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Appendix. Interview guide

I. Introduction

Introduction about who we are and the objective of the activity. We are a group of people, researchers from the Faculty of Medicine of the University of Antioquia who are carrying out a study in which with a series of questions we would like to know your opinion about things in health that you believe should or should not be provided to people without them having to pay extra money out of pocket or pay for it privately.

We call these "things in health" technologies, and with that word we refer to medications, medical consultations, surgeries, laboratory tests or radiology images, vaccines, devices, that is, everything that serves to make a diagnosis, to treat an illness or condition, or/and for health rehabilitation.

Clarifications on the voluntary nature of participation. If there is any question that you do not want to answer or if you want the interview to stop, there is no problem, you can calmly indicate this to the interviewer.

You can respond calmly as this interview is confidential. If you accept, we will record it, and when it is finished it will be transcribed. When it is transcribed, we will eliminate your name from it, and with that written interview we will do the analysis for the investigation. We appreciate your space and availability for this meeting.

Is it okay if we start recording?
Can you tell me your position (occupation)?
How long have you been in this position (occupation)?

II. Interactive communication process: preparation of questions

1. What should be covered or paid for with health system resources? Why?

Everything/some things/most things
Depends on the person's ability to pay
Depends on the age of the patient
Depends on the disease
Depends on how expensive the technology is
Depends on the effectiveness of the technology
Everything that the doctor orders/what the Constitutional Court says/what is defined in a benefit plan
It is affected by factors such as corruption, distrust in IPS or EPS, lack of participation in decisions on inclusion/exclusion, other

2. In your personal or family experience, do you remember any technology you have paid for privately that the health system should cover? (medications, surgeries, medical examinations, consultation with specialists, other therapies such as naturopathic therapies). Why?

Ordered by doctor
It is effective
It's expensive
It is fair/dignified/equitable/for a vulnerable group

3. What health technologies do you consider people should pay for privately and not publicly funded? Why?

None/some things/most things
Depends on the patient's ability to pay
Depends on the age of the patient
Depends on the disease

Depends on how expensive the technology is

Depends on the effectiveness of the technology

Anything that is not ordered by the doctor/what is denied in guardianship/what is not included in a benefit plan

The cosmetic, the experimental, what is offered outside the country, what has not been proven to be effective, What is not approved for use

It is affected by factors such as corruption, distrust in IPS or EPS, lack of participation in decisions on inclusion/exclusion, other

I am going to briefly present some example situations that arise in the health system, and then I will ask you if you believe that, in that situation, the technology should be paid for with public or private resources.

Case 1

"The mother of a 12-year-old boy with cerebral palsy filed a guardianship against the EPS

after she refused to give him 180 diapers and three packages of wet wipes for a period of three months, among other requests that a hospital in Yopal had made. EPS X granted the requested medications but denied coverage of diapers and wet wipes, arguing that they were elements not covered by the Health Benefits Plan." (Newspaper El Espectador march 23, 2018)

Should the health system cover diapers for this child?

Do you think that the health system should provide diapers to all people who require them, or should they be purchased by the families' own expense? Why?

Case 2

The father of 10-month-old twin girls, who suffer from a very rare disease (Spinal Muscular Atrophy), which only 70 people have in Colombia, filed a guardianship requesting that the pharmacological treatment of his daughters (Spinarza) be covered. The treatment has few studies that evaluate it properly, and those that exist show that it can **improve 1 in two children's** ability to carry out some movements (raising arms or controlling the head, for example). Still, it does not change the course of the disease. This treatment costs 551 million pesos for each injection, and one year's treatment for the two girls would be 7,346 million pesos.

Should the health system cover the twins' medication?

Do you think that highly expensive medications should be covered with public resources from the health system? Why?

Case 3

A 59-year-old woman was ordered to undergo reconstructive breast surgery after suffering from cancer. EPS X denied her surgery, stating that her breast reconstruction was a cosmetic surgery, which has no effect on the treatment of her disease. (Newspaper El Tiempo, February 20, 2019)

Should the health system cover breast surgery for this woman?

Do you think that cosmetic breast augmentation surgeries should be covered with public resources from the health system? Why?

Case 4

"In Colombia, when we talk about "alternative therapies," we refer to techniques and practices different from conventional medicine. That is, acupuncture, aromatherapy, oriental medicine practices or homeopathic medicine fall into this group. However, centers that do aba, equine therapy, dog-assisted therapy, dolphin therapy, among others, are NOT considered alternative therapies." (Commentary Eliech, July 4, 2013: http://agaviria.co/2013/06/terapias-aba-otro-fraude-al-sistema-de.html)

Do you think that these types of therapy should be covered with public resources from the health system? Why?

III. Close

We thank you for your time and willingness to participate in this space, we reiterate the importance of your participation in the project and we also ask the following questions to close the activity:

1. Is there anything else you would like to add about what was mentioned above?
2. Do you have any questions to ask me?
3. Do you have any concerns before I stop recording?

Thank you for answering these questions and sharing your views.