

SCANNING THE STRUCTURED PLURALISM IN THE COLOMBIAN HEALTH SYSTEM

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Recibido para publicación: 09-11-2020 - Versión corregida: 16-06-2022 - Aprobado para publicación: 19-07-2022

Holguín-Zuluaga J.A., Moncayo-Mora J.F., Trejos-Marín N. **Scanning the Structured Pluralism in the Colombian Health System.** *Arch Med (Manizales)*. 2021. 23(1):195-198.
<https://doi.org/10.30554/archmed.22.2.4061.2022>

Keywords: *Health Systems; Health Status Disparities; Colombia; (Source DeCs Bireme)*

In relation to the article: Vol. 18 Núm. 1 (2018) "Estado de salud de los colombianos: una aplicación del eq-5d-3l"

To the editor:

Social changes that occurred in developed countries over time, occurred in Latin America quickly and at different rates from the second half of the 20th century to the present day, generating inequalities and inequities, which has forced an attempt to adjust health care systems to the challenges posed by current and future needs and problems. Colombia, as a developing country, is no stranger to this transformation process. On one end, it must find a solution to the accumulated setbacks typical of underdeveloped societies (infectious diseases, malnutrition, reproductive health problems) and on the other hand, find a way to overcome the difficulties of industrialized nations (demographic aging, climate change and unhealthy lifestyles)[1].

A valid alternative is the Structured Pluralism Model proposed by Londoño and Frenk (1997), which raises health systems in terms of the relationship between population and institutions. It promotes equity, quality, and efficiency, and investigates a midpoint between the extremes. Harmful health care systems show the authoritarian monopoly of the public sector and the atomization without clear rules of the private sector [1][2]. It also defends a balanced distribution of power, in which the health system is organized by functions and not by social groups [2], and integrates the population horizontally with the assignment of clear, express and specialized activities [2] to secure tasks of articulation, financing, modulation and provision of the service with a view to improving capacities and roles [3].

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In Colombia, before Law 100 of 1993, the biggest problems were the obstacles of citizens with low or no income to health services access, together with the financial structure of the National Health System, which granted half of the public resources via social security to 20% of the population, corresponding to those with formal (paid) jobs, and the other half to the public network -the remaining 80%-, situations of blatant inequity. However, applying Frenk and Londoño concepts of Structured Pluralism and respecting the law, in the last 23 years, according to information from the Ministry of Health and Social Protection, it has gone from 29.21% in total coverage of the health system to 94.66%. Lack of care in case of illness went from 33.2% in 1993 to 1.3% in access to services, especially among those with fewer resources, and consultations for prevention doubled between 1997 and 2010 [4].

Still, the outlook is not entirely encouraging. The reform, promising in its conception, took an undesired direction, since the quality in health is deficient. The recognition of human talent in health is regrettable, the preventive actions have not been relevant and the financial flows, the high costs and the Corruption, has exceeded the regulatory intent of the regulatory adjustments (Laws 1122 of 2007 and 1438 of 2011) [4]. Without ignoring that the system has a moribund approach, is agent-centric, has a high disease burden and there is little resolution at level I, little development at level II, and there is congestion at level III. Additionally add fragmentation, disintegration of care, regional and population health inequities, decentralization problems, weakness and lack of articulation in the management of agents, scarce community participation, negative incentives among the agents of the system, market failure, regulatory failure, financial sustainability challenges, mistrust, lack of transparency among agents and very low reputation [5].

As an effort to leave the crisis behind, the National government now replaced the comprehensive approach, through the Comprehensive Health Care Policy (PAIS) and the Comprehensive Health Care Model (MIAS), with the Health Care Model Integral Territorial (MAITE) and the Comprehensive Health Care Routes (RIAS). It aims to advance the purpose of articulating and harmonizing the insurance, the provision of health services and the development of policies and programs in public health in accordance with the health situation of individuals, families and communities. Everything, to support intersectoral social and political management, taking into account the population and territorial contexts and the differential approach [6].

Those who doubt these regulatory measures are not silent. Among the criticisms made of PAIS are the belief that it is possible to unite entities with different objectives, since it is argued that Healthcare Providers (EPS) have dedicated themselves to reducing costs and have shown their interest in doing business with economic profit, leaving the health secondary in line. The same happens with territorial entities: their concern is the bureaucratic and patronage power that is reflected in the health of the population. On the other hand, the Health Providers Institutions (IPS) have made mistakes when exploiting health professionals, and in addition there have been abuses in the system by users [7].

In any case, the disappointment of the MAITE is that it does not eliminate the structural failures of the health system, since it continues to discriminate against the population

according to their ability to pay, which questions health as a fundamental, universal human right that can be guaranteed, regardless of race, gender, place of residence and economic capacity. Likewise, it is mentioned that since it is a resolution, it does not correct fragmentation, which leads to a lack of comprehensiveness, favoring inefficiency and the waste of money, since financial intermediation is not resolved, which continues to be in the EPS that they retain the competence to organize care networks and the training of human talent in health [8].

By way of conclusion, Londoño and Frenk's Structured Pluralism Model proposes to guide the reforms to the health systems of Latin America with a systemic approach that integrates populations and institutions. It needs to face double challenge of eliminating the burden of accumulated problems and, at the same time, address emerging difficulties, in a practical way, avoiding harmful extremes, promoting equity, quality and efficiency through a balance between the legitimate interests of all stakeholders. The way: progressive horizontal integration in a pluralistic system organized by functions.

The proposal is modulation as a core public responsibility, with fair rules of the game and financing as the central mission of a renewed social security, adapted to the new economic, social and political conditions in Latin America. In short, articulation as an opportunity for improvement thanks to simple and creative instruments that mediate transactions and the provision of services as a space for pluralism and proportional incentives [2].

Stated briefly, Colombia with the reform proposed by Structured Pluralism has perfected aspects of coverage and financial distribution. However, it remains in doubt whether these and other changes were more in form than in substance, or if they were due to the satisfaction of market demands to a greater extent than to the satisfaction of needs according to priorities. The result: less equity, quality and efficiency and a modulation limited to legal and legal analysis This is due to those who consider that more than a reform, what has been done is a redefinition of the health system, "a change of script with the same actors" [4]. For this reason, if a culture of corruption is maintained, the private interest is privileged over the collective. If politicking continues to prevail in the public, no matter how much restructuring is carried out, there will always be "things" that do not work and produce inefficiency and inequity [4].

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