Kolumbien: Zugang zu psychotherapeutischer Behandlung

Schnellrecherche der SFH-Länderanalyse

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Diese Recherche basiert auf Auskünften von Expertinnen und Experten und auf eigenen Recherchen. Entsprechend den COI-Standards verwendet die SFH öffentlich zugängliche Quellen. Lassen sich im zeitlich begrenzten Rahmen der Recherche keine Informationen finden, werden Expertinnen und Experten beigezogen. Die SFH dokumentiert ihre Quellen transparent und nachvollziehbar. Aus Gründen des Quellenschutzes können Kontaktpersonen anonymisiert werden.

Impressum

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1 Einleitung

Einer Anfrage an die SFH-Länderanalyse sind die folgenden Fragen entnommen:

1. Besitzt Kolumbien die nötige Infrastruktur zur Behandlung von Personen mit Traumatisierungen, multiplen Persönlichkeitsstörungen, rezidivierenden depressiven Störungen und posttraumatischen Belastungsstörungen (PTBS)?
2. Wie funktioniert der Zugang zu psychiatrischer Versorgung in Kolumbien? Werden die Kosten von einer Krankenversicherung oder von einem staatlichen Gesundheitsprogramm übernommen?
3. Sind die folgenden Medikamente oder vergleichbare Generika in Kolumbien erhältlich? Wenn ja, zu welchem Preis und in welcher Dosis?
    a. Escitalopram 10mg
    b. Risperdal 1mg
    c. Temesta 1mg

Die Informationen beruhen auf einer zeitlich begrenzten Recherche (Schnellrecherche) in öffentlich zugänglichen Dokumenten, die der SFH derzeit zur Verfügung stehen, sowie auf den Informationen von sachkundigen Kontaktpersonen.

2 Verfügbarkeit psychiatrischer Behandlungen

Zu wenig Plätze in der Psychiatrie. Überlastete Dienste. Psychiater_innen hauptsächlich in den grossen Städten. Laut *Chaskel et al*. gibt es in Kolumbien ungefähr 900 Psychiater_innen (davon 45 Kinder-Psychiater_innen) und 1500 Psycholog_innen. Sie leisteten psychiatrische Versorgung in den spezialisierten medizinischen Zentren, Allgemeinspitälern und psychiatrischen Einrichtungen. Fast 90 Prozent der Psychiater_innen würden in den zehn grössten Städten Kolumbiens praktizieren (*Chaskel, et al*., November 2015). *Tamayo-Agudelo und Bell* bestätigen, dass psychiatrische Gesundheitsdienstleistungen hauptsächlich in den städtischen Zentren erhältlich sind. In ländlichen Gebieten, die vom Konflikt besonders betroffen sind, würden sie häufig völlig fehlen oder seien selten. Ausserdem sei die psychiatrische Versorgung unterfinanziert (*Tamayo-Agudelo & Bell*, 2018). Gemäss *Borgen Magazine* unternimmt die Regierung zwar Anstrengungen, um die psychische Gesundheit zu fördern, doch seien die Bedürfnisse noch nicht gedeckt. Die Einrichtungen für psychiatrische Behandlungen seien überbelegt, weil es zu wenige Plätze gebe (*Borgen Magazine*, 18.November 2020). Laut *Chaskel et al*. nahm die Anzahl Plätze, von denen sich 75 Prozent in öffentlichen Spitälern befinden, zwischen 2005 und 2015 ab. Deshalb seien die psychiatrischen Dienste überlastet (*Chaskel et al*., November 2015).

Psychiatrische Versorgung unzureichend für die vielen Menschen, die in Kolumbien an psychischen Problemen leiden. Die psychiatrischen Kliniken sind überbelegt. Es ist schwierig, eine multidisziplinäre, langfristige Behandlung zu erhalten. Es gibt insbesondere in den grossen Städten qualitativ hochstehende psychotherapeutische Dienste im privaten Sektor, aufgrund der hohen Preise sind sie jedoch für die Mehrheit der Bevölkerung nicht zugänglich. Laut einer E-Mail vom 16. März 2021 an die SFH von einer *Kontaktperson, die Psychiater ist und als Professor in der Psychiatrie-Abteilung einer kolumbianischen Universität arbeitet,* gibt es in Kolumbien nicht die nötige Infrastruktur, um die

vielen Menschen mit psychiatrischen Krankheiten wie PTBS angemessen zu behandeln. Das Gesundheitssystem in Kolumbien sei noch sehr labil und biete eine unzureichende, unangemessene und qualitativ schlechte Versorgung an, insbesondere im Bereich der psychischen Gesundheit. Im Privatsektor gebe es insbesondere in den grossen Städten international anerkannte Fachpersonen im Bereich der psychischen Gesundheit sowie Psychiater_innen und Psycholog_innen. Doch seien diese Dienstleistungen aufgrund der hohen Preise nur für eine Minderheit der Bevölkerung zugänglich. Es gebe einen grossen Unterschied zwischen den Honoraren von Psychiater_innen, je nachdem ob es sich um eine Erstuntersuchung oder um eine Kontrolluntersuchung handle. Laut dieser Kontaktperson variieren die Honorare zwischen 40 und 100 Schweizer Franken pro Untersuchung. Laut einer E-Mail vom 12. März 2021 an die SFH von einer *Kontaktperson, die praktizierende Psychiaterin in der Stadt Cali* ist, ist die Infrastruktur für psychiatrische Versorgung in Kolumbien allgemein unzureichend. Patient_innen mit unterschiedlichen psychischen Problemen wie PTBS, Depressionen und multiplen Persönlichkeitsstörungen, die eine langfristige Behandlung durch multidisziplinäre psychiatrische Fachpersonen benötigen, könnten kaum angemessene Behandlungen erhalten. Diese *Kontaktperson* gibt an, dass es zwar ausgebildete Fachpersonen gebe, der Zugang zu ihnen aber schwierig sei, und sie würden nicht alle an einem Ort arbeiten. In den Spitälern gebe es zwar eine Infrastruktur für akute Krisen, doch seien sie immer überlastet. In Cali sei die Notfallaufnahme im einzigen staatlichen psychiatrischen Spital mehr als 200 Prozent überbelegt. Es gebe keinerlei psycho-soziale Rehabilitationsprogramme im öffentlichen oder privaten Gesundheitsplan.

Lange Wartezeiten für Personen mit gesetzlicher Krankenversicherung für reguläre Termine bei Psychiater_innen. Laut einer E-Mail vom 12. März 2021 an die SFH von einer *Kontaktperson, die als Psychiaterin in der Stadt Cali arbeitet*, werden wöchentliche psychotherapeutische Sprechstunden von der gesetzlichen Krankenkasse nicht übernommen. Für einen Termin bestünden Wartezeiten von mehr als drei Monaten. Ausserdem benötige man dafür eine Bewilligung, die ebenfalls drei Monate dauern könnte. Es sei möglich, einen Termin für eine Sprechstunde in einer Privatklinik zu erhalten, die Krankenversicherung bezahle aber nur die erste Sprechstunde und keine langfristige psychotherapeutische Behandlung. Laut einer E-Mail vom 16. März 2021 an die SFH von einer *Kontaktperson, die Psychiater ist und als Professor in der Psychiatrie-Abteilung einer kolumbianischen Universität arbeitet*, ist es für eine Person, die ausschliesslich auf das öffentliche Gesundheitswesen angewiesen ist, sehr schwierig, eine angemessene psychotherapeutische Behandlung zu erhalten. Das liege insbesondere daran, dass es äusserst schwierig sei, einen Termin bei Spezialist_innen zu erhalten. Wenn es gelänge, einen solchen Termin zu erhalten, sei die Häufigkeit der Behandlung generell unzulänglich (zum Beispiel einmal pro Monat). Doch laut der E-Mail vom 8. März 2021 an die SFH von einer *Kontaktperson, die als Psychologe für eine staatliche Institution arbeitet*, könne eine Person, die dem Krankenversicherungssystem angeschlossen sei, eine psychiatrische Begleitung und sogar Medikamente erhalten. Wenn der oder die Psychiater_in es für nötig erachte, habe man auch das Recht auf eine stationäre Behandlung. Wenn diese Person keine Krankenversicherung habe, müsse sie sich privat behandeln lassen und die Behandlung sowie Medikamente selbst bezahlen.

Zugang zu psychiatrischer Versorgung im Prinzip gesetzlich garantiert. Ein Programm zur sozialen und psychologischen Unterstützung für Opfer des bewaffneten Konflikts ist gesetzlich vorgesehen, doch die Wirksamkeit des Programmes ist unklar. Laut *Borgen Magazine* versucht die kolumbianische Regierung seit den 90er-Jahren den Zugang zur

psychischen Gesundheitsversorgung für die Bevölkerung zu verbessern. Doch sei die nationale Politik in Bezug auf die psychische Gesundheit von 1995 und 1998 insbesondere aufgrund von wirtschaftlichen Engpässen nicht sehr erfolgreich gewesen. Im Jahr 2011 verabschiedete die Regierung das «Opfer- und Landrückgabegesetz», das auch als das Gesetz 1448 bekannt ist. Dieses Gesetz garantiert allen Menschen, die von Gewalt und interner Vertreibung betroffen sind, finanzielle Unterstützung für psychische Behandlungen einschliesslich stationäre und psychotherapeutische Programme. Im Jahr 2013 wurde mit dem Gesetz 1616 die psychische Gesundheit zum Grundrecht. Damit steht die Regierung in der Verantwortung, die Förderung, Prävention und Intervention in Bezug auf die psychische Gesundheit umzusetzen. Laut *Borgen Magazine* enthält das Gesetz ebenfalls wichtige Bestimmungen zur Entwicklung von Kampagnen zur Beseitigung von Stigmatisierung und Diskriminierung von Personen mit psychischen Erkrankungen (*Borgen Magazine*, 18. November 2020). Laut *Tamayo-Agudelo und Bell* muss die Wirksamkeit dieser Programme erst noch nachgewiesen werden, auch wenn die vorrangige Behandlung von Opfern des Konflikts in Bezug auf die psychische Gesundheit gesetzlich verankert sei. Durch das Gesetz konnte ein soziales und psychologisches Unterstützungsprogramm für die Opfer des bewaffneten Konfliktes eingerichtet werden. *(Programa de atención psicosocial y salud integral a víctimas*; PAPSIVI). Ziel des Programmes sei es, den Zugang zu psychischen und psychiatrischen Gesundheitsdienstleistungen für vom bewaffneten Konflikt betroffene Personen deutlich zu verbessern. Das soll hauptsächlich über Medikamente, Psycholg_innen und Sozialarbeiter_innen in den Gemeinden geschehen. Diese Quelle unterstreicht, dass dieses Programm tatsächlich vielversprechend sei, doch würde es nur sehr schleppend umgesetzt. Laut *Tamayo-Agudelo und Bell* stellt sich auch die Frage, ob mit diesem Programm tatsächlich Millionen von Menschen eine psychische Gesundheitsversorgung erhalten könnten (*Tamayo-Agudelo & Bell*, 2018).

Die meisten Personen mit psychischen Problemen erhalten keine angemessene Behandlung. Stigmatisierung und Ausgrenzung von Personen mit psychischen Problemen als grosses Hindernis beim Zugang zu psychiatrischer Versorgung. Laut der *Pan American Health Organisation* (PAHO) litten im Jahr 2015 in Kolumbien einer von zehn Erwachsenen an psychischen Problemen. Angstzustände, Depressionen und Psychosen waren dabei die häufigsten Probleme. Bei Kindern zwischen sieben und elf Jahren mit psychischen Problemen erhielten 92 Prozent eine Behandlung. Bei Erwachsenen betrug diese Zahl nur 38 Prozent (PAHO, undatiert). *Palacio* macht darauf aufmerksam, dass Personen mit psychischen Problemen in Kolumbien kulturell und sozial stigmatisiert würden und dass dieses Problem nicht sehr ernst genommen werde. Häufige psychische Störungen wie Angststörungen und Stimmungsschwankungen werden von den Betroffenen, und vor allem vom medizinischen Personal, nicht erkannt. Gemäss dieser Quelle seien die Zahlen alarmierend: Von den 60 Prozent der Personen, die sich beim Gesundheitsdienst wegen Depressionen und Angstzuständen melden, werden nur 30 Prozent untersucht und diagnostiziert. Und von ihnen erhalte eine noch geringere Prozentzahl eine Behandlung. Nur sehr wenige Personen mit psychischen Problemen würden eine angemessene Behandlung erhalten (*Palacio*, Dezember 2018). Laut *Chaskel et al.* werden viele Soldaten, die an Posttraumatischen Belastungsstörungen (PTBS) leiden, nach ihrer Demobilisierung nicht behandelt (*Chaskel et al*., November 2015). *Ricardo Zaraza-Morales & Hernández-Holguín* bestätigen ebenfalls, dass der Zugang zu qualitativ hochstehender Behandlung weiterhin schwierig sei, auch wenn es Fortschritte bei der Priorisierung der psychosozialen Versorgung gibt. Grund dafür seien insbesondere die Diskriminierung und Ausgrenzung von Personen mit diesen Erkrankungen (*Zaraza-Morales & Hernández-Holguín*, 2015).

3 Verfügbarkeit und Kosten von spezifischen Medikamenten

Generika werden vom Staat kostenlos oder mit geringer Selbstbeteiligung zur Verfügung gestellt, doch die Qualität ist häufig mangelhaft. Keine Lieferungs- und Zulassungsgarantie für Medikamente, was die Kontinuität der Behandlungen gefährdet. Laut einer E-Mail vom 16. März 2021 an die SFH von einer *Kontaktperson, die Psychiater ist und als Professor in der Psychiatrie-Abteilung einer kolumbianischen Universität arbeitet*, werden Generika im öffentlichen Sektor kostenlos oder mit einem Selbstbehalt von ungefähr 10 Schweizer Franken abgegeben. Doch die Qualität dieser Medikamente sei häufig mangelhaft, da die kolumbianische Gesundheitsbehörde INVIMA keine Bioäquivalenzstudien für die Markzulassung verlange. In vielen Fällen müssten die kolumbianischen Psychiater_innen mit Hilfe eines Formular namens FORAM Meldung erstatten, dass die Patient_innen nicht in gleicher Weise auf die Generika reagieren. In einigen Fällen sei es dann möglich, vom öffentlichen Gesundheitssystem das Originalprodukt zu erhalten. In anderen Fällen müssen die Patient_innen eine sogenannte «Vormundschaft», ein verfassungsrechtlicher Mechanismus zur Einforderung ihrer Gesundheitsrechte, beantragen. Wenn der Richter zu Gunsten des/der Patient_innen entscheide, müsse das System den Patient_innen dann die Originalmedikamente zur Verfügung stellen, die er oder sie dann bei seinem Arzt beantragen kann. Laut einer E-Mail vom 12. März 2021 an die SFH von einer *Kontaktperson, die als Psychiaterin in der Stadt Cali arbeitet*, hängt es von der Art der Krankenversicherung ab, ob die Kosten für Medikamente übernommen werden. Die Medikamentenkosten könnten offiziell übernommen werden, doch gebe es keinerlei Garantie, dass sie von den Behörden jeden Monat geliefert werden. Dadurch sei die Kontinuität der Behandlung gefährdet.

a. Escitalopram

Laut einer E-Mail vom 12. März 2021 an die SFH von einer *Kontaktperson, die als Psychiaterin in der Stadt Cali arbeitet*, ist *Escitalopram* in einer Dosierung von 10mg erhältlich. Der Preis schwankt zwischen 55‘000 und 280‘000 Pesos oder zwischen 14.40 und 73.15 Schweizer Franken[1] pro Monat. Laut einer E-Mail vom 16. März 2021 an die SFH von einer *Kontaktperson, die Psychiater ist und als Professor in der Psychiatrie-Abteilung einer kolumbianischen Universität arbeitet*, ist *Escitalopram* unter verschiedenen Namen erhältlich, auch das Originalprodukt *Lexapro*. *Lexapro* sei teuer, doch die in Kolumbien verkauften europäischen Generika (*Galenicum, Altadis*) seien billiger und kosteten ungefähr 30 Schweizer Franken pro Monat.

b. Risperdal

Laut einer E-Mail vom 12. März 2021 an die SFH von einer *Kontaktperson, die als Psychiaterin in der Stadt Cali arbeitet*, ist *Risperdal* unter dem Namen *Risperdone* erhältlich und kostet 10‘000 Pesos oder 2.60 Schweizer Franken pro Monat, bei einer Dosis von 1mg. Laut einer E-Mail vom 16. März 2021 an die SFH von einer *Kontaktperson, die Psychiater ist und*

[1] Zum Wechselkurs vom 16. März 2021.

als Professor in der Psychiatrie-Abteilung einer kolumbianischen Universität arbeitet, ist *Risperdal* für einen staatlich festgelegten Preis erhältlich, damit die Bevölkerung Zugang dazu habe. Gemäss dieser Kontaktperson ist das vom staatlichen Gesundheitssystem ausgegebene *Risperidone* von schlechter Qualität.

c. Temesta

Laut einer E-Mail vom 12. März 2021 an die SFH von einer *Kontaktperson, die praktizierende Psychiaterin in der Stadt Cali* ist, ist *Temesta* in Kolumbien nicht erhältlich. Doch *Ativan*, das den gleichen Wirkstoff enthält, sei zum Preis von 46‘000 Pesos oder 12 Schweizer Franken zu einer Dosierung von 1mg erhältlich. Laut einer E-Mail vom 16. März 2021 an die SFH von einer *Kontaktperson, die Psychiater ist und als Professor in der Psychiatrie-Abteilung einer kolumbianischen Universität arbeitet*, sind ausser *Ativan* noch andere Generika erhältlich, und sie werden durch das staatliche Gesundheitssystem verteilt.

4 Gesetzliche Krankenversicherung

Fast 95 Prozent der Bevölkerung besitzen eine Krankenversicherung. Die Menschen sind verpflichtet, einem der zwei Krankenversicherungssysteme beizutreten: Einem beitragsfinanzierten oder einem subventionierten Plan. Der Leistungskatalog ist im Prinzip der Gleiche. Laut dem *Global Network for Health Equity* (GNHE) gibt es im kolumbianischen Gesundheitssystem zwei grosse Krankenversicherungssysteme. Zum einen gibt es das beitragsfinanzierte System, das für Mitarbeitende des formellen Sektors und andere Personen, die es bezahlen können, obligatorisch ist. Zum anderen gibt es das subventionierte System für Arbeitslose, Arbeitende im informellen Sektor und Arme. Im Jahr 2013 seien in Kolumbien ungefähr 93 Prozent der Bevölkerung in einem dieser beiden Systeme gewesen. Mehr als die Hälfte der Bevölkerung sei im subventionierten System (GNHE, November 2015). *Das Borgen Magazine* präzisiert, dass 56 Prozent der kolumbianischen Staatsbürger_innen auf das staatlich subventionierte Gesundheitsversorgungssystem angewiesen sind (*Borgen Magazine*, 18. November 2020). Laut *Chaskel et al*. wird das subventionierte System durch Steuern und andere Lohnabgaben der Beschäftigten finanziert (*Chaskel et al*., November 2015). Gemäss *Garcia-Ramirez et al.* haben die beiden Krankenversicherungen unterschiedliche Beitragssätze pro Person. Im Jahr 2018 lagen die Beiträge bei 246.90 US-Dollar, oder 230 Schweizer Franken[2] für Personen im Beitragssystem und 220 US-Dollar, oder 205 Schweizer Franken, für Personen im subventionierten System (*Garcia-Ramirez et al.*, 26. Oktober 2020). Gemäss der Internationalen Arbeitsorganisation (ILO) müssen sich alle Bürger_innen einem der beiden Krankenkassensystemen anschliessen (ILO, März 2014). *Garcia-Ramirez et al.* erklärt, dass trotzdem ein bedeutender Teil der Bevölkerung (2017 waren es 5.6 Prozent) nicht versichert sei. Es seien hauptsächlich Arbeitslose, Arbeitende im informellen Sektor, die weniger als den Mindestlohn verdienen und arme Familien, deren Einkommen über der Zugangsschwelle für staatliche Sozialleistungen im subventionierten System liege (*Garcia-Ramirez et al.,* 26. Oktober 2020). Mehrere Quellen bestätigen, dass beide Krankenversicherungssysteme die gleichen obligatorischen Leistungen haben (*Garcia-Ramirez et al.*, 26 Oktober 2020; GNHE, November 2015; ILO, März 2014). Laut einem gemeinsamen Bericht der Weltbank (WB) und der International Finance Corporation (IFC) ist die Abdeckung von

[2] Zum Wechselkurs vom 15. März 2021.

Gesundheitsleistungen umfassend, die finanzielle Absicherung hoch, und die privaten Ausgaben machten nur etwa 15 Prozent der gesamten Gesundheitskosten aus (WB & IFC, 17. Juli 2019).

Unterschiede in der Versorgungsqualität bei der staatlichen und der privaten Krankenversicherung über die Arbeitgebenden. Mehr als 34‘000 Kolumbianer_innen sterben jedes Jahr wegen schlechter Gesundheitsdienstleistungen und unzureichendem Zugang zur Gesundheitsversorgung. Laut *Tamayo-Agudelo und Bell* bietet das zweistufige Krankenversicherungssystem ein deutlich geringeres Versorgungsniveau für diejenigen, die im staatlich subventionierten System sind. Ausserdem würden Korruption, die Reformblockade, Schulden im Gesundheitssystem und die Schliessung von Spitälern und Kliniken für psychische Gesundheit grosse Hindernisse darstellen (*Tamayo-Agudelo & Bell*, 2018). Das *Borgen Magazine* bestätigt ebenfalls, dass Ungleichheiten zwischen der Behandlungsqualität in der subventionierten Versorgung und der Versorgung des Rests der Bevölkerung bestehen, die über ihre Arbeitgebenden versichert seien (*Borgen Magazine*, 18. November 2020). *Chaskel et al.* unterstreicht ebenfalls, dass es grosse Unterschiede bei den zwei Krankenversicherungssystemen gebe. Ausserdem sei das kolumbianische Gesundheitssystem in einer schweren Krise aufgrund der allgemeinen Korruption und des Regulierungsversagens *(Chaskel, Roberto et al*., November 2015). Laut dem gemeinsamen Bericht der Weltbank (WB) und der *International Finance Corporation* (IFC) gibt es immer noch erhebliche Bedenken hinsichtlich der Versorgungsqualität. Diese Quelle zitiert eine Studie der Lancet-Kommission für globale Gesundheit aus dem Jahr 2018, laut derer jedes Jahr mehr als 22‘000 Kolumbianer_innen aufgrund von schlechter Behandlungsqualität sterben sowie weitere 12‘000, weil sie keinen Zugang zu Dienstleistungen haben oder sie nicht nutzen können (WB & IFC, 17. Juli 2019). Laut einer E-Mail vom 16. März 2021 an die SFH von einer *Kontaktperson, die Psychiater ist und als Professor in der Psychiatrie-Abteilung einer kolumbianischen Universität arbeitet*, erhalten Personen im subventionierten System im Prinzip unter anderem medizinische Versorgung (Erstversorgung und spezialisierte Behandlungen), Spitalaufenthalte und chirurgische Eingriffe sowie «essentielle» Medikamente. Doch das System sei noch sehr mangelhaft und würde keine angemessene Gesundheitsversorgung für die gesamte Bevölkerung garantieren.

5 Quellen

Borgen Magazine, 18. November 2020:

> *« After decades of armed conflict, Colombia was finally able to institute a peace agreement with the largest rebel group in the nation in 2016. Lingering violence and years of trauma has come at a cost: high rates of mental illness within populations affected by the conflict.* ***The Colombian Government has enacted new legislation to support the growing number of mental health needs but there are still needs left unmet. There are domestic and international organizations working to bolster the public mental health resources available to improve mental health in Colombia****. […]*
>
> ***In an attempt to reach universal healthcare coverage, Colombia has created a two-tiered healthcare system. The impoverished account for a portion of the 56% of Colombia’s citizens that rely on government-subsidized healthcare. There are disparities between***

the quality of treatment within the subsidized care and the care provided to the rest of the population that receives insurance through their employment.

There is overcrowding in spaces for psychiatric treatment due to insufficient beds. Additionally, 90% of the estimated 900 psychiatrists in the country, as of 2015, are found within Colombia's 10 largest cities, which leaves rural areas with fewer mental health resources.

Efficacy of Colombian Mental Health Law
The Colombian Government has aimed to make progress within mental health in Colombia since much earlier than the past decade but insufficient funding has hindered the implementation of policy. ***National mental health policies from 1995 and 1998 were unable to achieve much success due to economic restrictions. Extensive change in legislation and the healthcare system offers hope for a more progressive future for mental health in Columbia***.

To directly target the high number of mental health issues that stemmed from national conflict, the Colombian Government passed "The Law of the Victims and Land Restitution," also known as Law 1448, in 2011. All people affected by violence and internal displacement are ensured resources for mental health treatment under this legislation, including in-patient programs and psychotherapy. Law 1448 requires that mental health services receive at least 10% of the budget of all health prevention and promotion programs.

In January of 2013, mental healthcare was designated as a fundamental right by Law 1616. It places responsibility on the federal government to implement promotion, prevention and intervention for mental health. Developing campaigns the eliminate the stigmatization and discrimination toward mental illness is another significant element of the law. » Quelle: Borgen magazine, The Future of Mental Health in Colombia, 18. November 2020: www.borgenmagazine.com/mental-health-in-colombia/.

Chaskel et al., November 2015:

« ***Colombia's expenditures for healthcare, equivalent to 7.6% of the GDP, fund a two-tiered system that has attempted to achieve nearly universal coverage (Yepes Lujan, 2012). The contributory health insurance system for employers and their formally contracted employees covers healthcare provided by 22 'EPSs' (akin to health maintenance organisations) for 44% of the Colombian population. The remainder, including those who are poor or unemployed, receive 'subsidised' healthcare paid for by taxes and other deductions from workers' pay. There are gross disparities between the coverage and care provided within the two systems and Colombia's healthcare faces a grave crisis due to widespread corruption and regulatory failures*** *(Yepes Lujan, 2012). A mechanism has been put in place to allow persons to sue for delivery of proper medical care but, in practice, this is crippling the system.*

Mental health needs and care access
The number of psychiatric beds has decreased over the past decade, leading to overcrowding. About 75% of psychiatric beds are in public hospitals. In contrast, the military

facilities are well equipped; however, many soldiers with post-traumatic stress disorder (PTSD) go untreated following their discharge and return to their rural communities.

Mental health workforce
About 900 psychiatrists (including 45 child psychiatrists) and 1500 psychologists are tasked with delivering mental healthcare in specialty medical centres, general hospitals and psychiatric facilities. Ninety per cent of psychiatrists are concentrated within Colombia's ten largest cities*. Specialisation in psychiatry requires a 3-year residency programme (residents pay for their tuition and receive no compensation) based in 11 medical schools nationwide; currently about 100 resident physicians are in training. Psychiatric training focuses on psychodynamic therapies and pharmacotherapy, with the recent addition of training in cognitive–behavioural and systemic therapies. »* Quelle: Chaskel et al., Mental health in Colombia, November 2015: www.ncbi.nlm.nih.gov/pmc/articles/PMC5618872/.

Garcia-Ramirez and al., 26. Oktober 2020:

« In the 2000 World Health Report, the World Health Organization (WHO) awarded Colombia with the top ranking worldwide for fairness in healthcare finance. This accolade came amidst ravaging civil war throughout the country. Nineteen years later, both Colombia's social and economic landscapes have improved dramatically. A question arises as to whether the health system in Colombia has progressed at a similar rate].

*Prior to 1993, Colombia had a National Social Security system which provided insurance to less than 24% of the population and catered mostly to wealthy individuals and formal public employees]. The provision of health services under this system occurred through a network of public hospitals****. In an attempt to improve healthcare coverage, in 1993, Colombia implemented a major reform to its health system by creating the 'General System of Social Security in Health' through the enactment of Law 100. This reform introduced a mandatory health insurance model based on managed competition between private insurers. By 2017, 94.41% of the population of 45.5 million Colombians was insured. Of those who were insured, 90.24% were covered by one of the two main insurance schemes: the contributory scheme (CS) for the formal workers, or the subsidized scheme (SS) for those without the ability to pay. A smaller proportion (4.17% in 2017) of the population belongs to a special scheme for public teachers, the armed forces, and workers from the state oil company. Despite the major improvement in healthcare coverage in Colombia, there is still a fair portion of the population (5.59% in 2017) who remain uninsured which is comprised of the unemployed, informal workers earning less than minimum wage, and poor families who score above the income threshold for government social benefits under the subsidized scheme.***

Colombia has made great strides in healthcare financing since reforming its social security system in 1993. ***In 2015, Colombia spent 6.19% of its GDP on healthcare, and 76% of total health expenditure (THE) was public****. In addition, per capita health spending increased from US$360.67 in 2000 to US$382.10 in 2016 (in constant 2000 prices).* ***Despite these improvements in national health spending, Colombians continue to pay out-of-pocket for healthcare services (18.3% of THE in 2015).***

In order to finance the various insurance schemes offered, the Colombian government collects and pools payroll taxes and general taxe. It subsequently allocates resources to 45 competing

*private insurers based on a per-capita premium adjusted for age, gender, geographic distribution of enrollees, and type of coverage scheme (CS or SS**). Both CS and SS coverage schemes have a different premium base per individual. In 2018, the premiums were US$246.9 and US$220 for CS and SS respectively. Insurers must guarantee the provision of services covered in the health benefits package (HBP), which—since 2012—is identical for both schemes and is updated by the government annually.***

The 1993 reform of the health system split purchasing and providing functions. Private insurers selectively contract services from public and private health providers. Fees for services and payment schedules are not defined by government and instead are negotiated between insurers and providers. The government is responsible for general stewardship of the system and for the regulation of quality, solvency, and accounting standards of insurers and providers. This fragmentation of the system has arisen as a concern due to its negative impacts, including: lack of coordination between the multiplicity of payers and providers, the burden of administrative bureaucracy to authorize treatments, and deficient organization across levels of care in the territories. » Quelle: Garcia-Ramirez and al., Inequality in healthcare use among older people in Colombia, 26. Oktober 2020: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-01241-0.

GNHE, November 2015:

*« **The Colombian health system has two major health insurance schemes. The contributory regime is mandatory for formal workers and other people with the capacity to pay. The subsidised regime is for the unemployed, informal sector workers and the poor.***

*The Colombian health system has made big efforts to fulfil the goal of universal health coverage. **Since 2000, health expenditure as a percentage of GDP has been around 6.8% and government health expenditure as a percentage of total health expenditure has been almost 80%. In 2010 all health system financial sources were progressive, meaning that higher-income individuals contributed relatively more towards the health system.***

***In 2013 the contributory and subsidised regimes covered approximately 96% of Colombia's population, and more than half the population was completely subsidised. There is a common mandatory benefit package**.*

The structure of the health system pools all resources into a common fund that is distributed on a risk-adjusted, capitation basis to a range of public and private health maintenance organisations. People are allowed to choose their health maintenance organisation, and health maintenance organisations are able to choose the providers with which they contract.

However, 4.6% of households in 2010 incurred catastrophic expenditure (measured using a 40% threshold of non-food household expenditure). Although this was an improvement from 2008, the intensity of catastrophic expenditures is still concentrated in low-income households. Data also suggest that the households that became poor after a financial shock were predominantly those in the subsidized regime and the uninsured.

In summary, Colombia has made important progress towards universal health coverage but attention still needs to be paid to the differences in access to health care for those with lower incomes and living in rural areas. » Quelle: Global Network for Health Equity (GNHE), Universal

Health Coverage Assessment, Colombia, November 2015, S.15: www.icesi.edu.co/proesa/images/GNHE%20UHC%20assessment_Colombia%204.pdf.

ILO, März 2014:

« After two decades of development, the Colombian health insurance system exhibits very positive results. It is estimated that the rate of affiliation to the social health insurance schemes rose from 25 per cent in 1993 before the reforms to 96 per cent in 2014.

Out-of-pocket expenditures (OOP) fell to 15.9 per cent of national total health expenditures in 2011 (MSPS, 2014). According to the ILO's World Social Protection Report 2014/2015, per capita health expenditure not financed by OOP reached 358.5 US$ and the share of live births attended by skilled health staff reached 99.2 per cent. Hence, Colombia is one of the most notable cases of recent progress in health protection in Latin America.

The Colombian health system is based on the principle of "universality", which means that all citizens are obliged to join one of two insurance schemes: a contributory plan for employees and self-employed workers with contributory capacity or a subsidized (non-contributory) scheme for informal workers and low-income self-employed workers.

Benefit packages. Members, either in the subsidized or the contributory scheme, are entitled to the same benefits**. **A single service package is defined by the Mandatory Health Plan (POS), which is composed of interventions aimed at health promotion, prevention, and medical care services, including pharmaceutical drugs for members and their families. The POS also includes cash benefits in case of illness and maternity leave. Public and private Health Promotion Entities (EPS), in their role as insurers, are responsible for ensuring citizens have access to POS entitlements.

***Financing. The Contributory Scheme is financed by compulsory contributions from employers, employees, the self-employed, and pensioners. Participants contribute according to their payment capacity. The Subsidized Scheme is financed by taxes and transfers from the Contributory Scheme**. A per capita payment to deliver the POS —the Capitation Payment Unit (UPC)— is transferred by the Government to the Health Promotion Entities according to the number of enrolled members in each EPS. Thus, EPSs compete for the enrolment of new members in order to maximize their revenue. A Solidarity and Guarantee Fund (FOSYGA) was created to provide cross-subsidies between schemes and finances promotion and prevention interventions.*

Legal aspects. The health system was created in 1993 by Law 100. Several reforms have been introduced over time in order to correct problems. In 2007, the Government approved a legal reform to improve stewardship functions, the financing, the financial balance, and the quantity and quality of current services. In 2011, further reforms were introduced to create a single POS for all residents (the former POS provided lower standards for the Subsidized Regime), reach universal coverage, and ensure territorial portability of benefits. Other reforms are currently under debate and highlight the divergent views on the health system among stakeholders. An element of concern is the increasing "judicialization" of the system, whereby the constitutional court has adopted several resolutions to guarantee to the whole population effective access to the POS.

Institutional arrangements for delivery. EPS insurers in the contributory and subsidized schemes purchase services from health provider institutions (IPS), which may be either public or private entities. Public hospitals became State-owned social corporations with legal personality, equity capital, and administrative autonomy. Thus, the system has public and private provision of health-care services.

Regulation and oversight of health insurers and providers is under the responsibility of a public entity called SuperSalud. Only people identified through SISBEN, a system for identifying social assistance beneficiaries, are entitled to non-contributory coverage (subsidized scheme). [...]

3. What are the main results in terms of impact on people's lives?
Outcomes High levels of affiliation (coverage) rates achieved by the Colombian social health insurance system have had positive implications for the well-being of the population. ***OOP fell dramatically from 43.7 per cent of national health expenditures in 1993 to 15.9 per cent in 2011 (MSPS, 2014), generating a considerable reduction in vulnerability for many Colombians. Thanks to the strong expansion in financing, total health expenditures financed with public resources reached 73.8 per cent in 2011 (MSPS, 2014), one of the highest rates in Latin America.***

Impacts on people's lives. ***One of the most remarkable achievements of Colombia is the extension of health protection and effective access to health services to rural and poor populations.*** *Several studies now show significant increases in the use of health services in rural areas. As a result, since the introduction of the health care reform in 1993, the number of infant and maternal deaths has fallen by 40 per cent and prenatal care has increased by 17 percentage points, with significant improvements in immunization rates for children under the age of 2, according to World Bank figures.*

Despite its accomplishments, the Colombian health system is not free of problems and criticisms*, including divergent views on the direction of future reforms.* ***Among the many challenges that remain to be addressed are:***

1. Complete universal access to health protection and effectively equalize the POS across schemes.
2. Close the gaps in the availability of health care particularly in rural areas through the provision of a sufficient number of health workers to ensure that all in need have effective access to quality health care.
3. Enhance efficiency and effectiveness of the overall health system
4. Improve scope and quality of health services and reduce denial of treatment by insurance companies.
4. Strengthen social dialogue as a part of the current model.
5. Increase membership in the contributory scheme in order to enhance fiscal sustainability through increased social contributions.
6. Improve national health account data and quality of information on health in order to strengthen government monitoring, planning and decision-making capabilities.
7. Improve the procedures for beneficiaries to appeal in case of denial of treatment, in order to reduce the use of the constitutional channel to appeal.
8. Reduce intermediation costs generated by EPSs.

9. Improve the regulatory framework and increase regulatory capacity of the State. » Quelle: International Labour Organization (ILO), Universalizing health protection, Colombia, März 2014, S.1-3: www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=48019.

PAHO, ohne Datum:

« ***Colombia's health system is made up of a social security sector and a private sector. The backbone of the system is the General Social Security Health System, which has two plans, contributory and subsidized; workers from certain institutions (5.4%) are covered by a third plan. The contributory regime covers salaried workers, pensioners, and independent workers, with the subsidized plan covering anyone who cannot pay. Enrollment coverage increased from 96.6% in 2014 to 97.6% in 2015.***

The National Health Authority's functions under the system include improving the quality of health care and strengthening supervision, surveillance, and control of health insurance.

Enrollment in the General Social Security Health System is compulsory and is handled through public or private health promotion agencies (known as EPS, from their Spanish acronym). The EPS deliver the funds from premium payments to the Solidarity and Guarantee Fund (FOSYGA), which then returns to them the amount equivalent to the payment per person, adjusted for risk, according to the number of members. Health care is provided by institutional health service providers, which may or may not be part of the EPS. Those who can afford to purchase health insurance coverage on their own and who can pay for any uncovered fees out-of-pocket use the private sector*. [...]*

According to data from the Ministry of Health there is 1 physician for every 0.6 nurses. In 2012, the ratio of physicians per 10,000 population was 17.7, 10.3 for nurses, and 8.3 for dentists. *Colombia has 55 medical programs, graduating an average of 5,000 physicians annually; the country has 65 nursing programs, graduating an annual average of 3,600 nurses. A family and community medicine approach is being developed under the Comprehensive Health Care Model to upgrade the skills of human resources. In 2015, the National Registry of Human Talent in Health listed 600,000 health professionals, technicians, and auxiliaries licensed to practice. [...]*

In 2015, 4 in 10 children aged 7 11 had a mental health problem, such as unexplained irritability and problems with peer relations. The main problems among adolescents were anxiety and depression, which were more common in women than men. ***In the population over 18, 1 in 10 persons had mental health problems, with anxiety, depression, and psychosis being the most common.***

Concerning access to mental health services, 92% of children aged 7 11 and 38% of adults received treatment. *Symptoms of depression and/or anxiety were more common in women than men (9.87% and 7.53%, respectively).*

In the age group 13 17 years old, 6.6% experienced suicidal ideation, 7.4% among girls and 5.7% among boys; of those who attempted suicide, 2.9% were male and 2.1% female. An uptick in suicide and psychoactive substance use has been observed among adolescents, particularly

in indigenous populations. » Source: Pan American Health Organisation (PAHO), Health in the Americas, Colombia, ohne Datum: www.paho.org/salud-en-las-americas-2017/?p=2342.

Palacio, Dezember 2018:

« In our region of Latin America, systems of health care are in crisis. The financing of an equitable and fair system is complicated and the state contribution for health it is not enough. In the mixed-financing systems, the contributive regime is both less than the subsidized regime and insufficient; in private systems, this ends up creating gaps that are then impossible to correct. The policies of mental health in a country must come from articulated actions focused around two priorities: primary prevention, with strategies of promotion and prevention that have a real impact on maintaining the well-being and the quality of life of a good percentage of the communities; and second, coherent development of the primary health care component (PHC) that provides access, opportunity, and quality in the treatment of mental events.

When speaking about mental health, it is important to highlight the problem of how it's culturally and socially stigmatized in our region, both for the subject that requires accompaniment and those who work in the area. Mental health is spoken of in pejorative tones, relegated to a subordinate place. Processes of education and raising awareness continue to be necessary to dismantle these taboos. It is common to find that many people have problems reflecting, analyzing and deciding to search for help when they or people close to them experience a mental alteration. We lack the simple and basic skills and competencies to adapt adequately to important situations that we face every day like interpersonal, family, or work conflicts that can be resolved with verbal mediation and the capacity to listen or a good tolerance for frustration, resilience, and the will to move forward despite the obstacles in our path. Nor do we possess the skills to know when there are signs or symptoms that indicate the presence of mental disturbances.

Mental disorders as common as anxiety and mood disorders are not recognized by those who suffer from them, or, even more seriously, by medical personnel. The figures are outrageous: 60% of the people who go to basic health care services have anxiety and depressive symptoms, only 30% of these are investigated and diagnosed, and an even lesser percentage receives appropriate treatment. Only a small percentage of people who have mental alterations receive adequate treatment. *The consequences are dramatic. Health indicators remain much lower than expected; even mortality rates are affected by problems such as self-aggression and hetero-aggression.*

Suicidal behavior has become a real mental health problem in the world, undoubtedly coming from both the aforementioned problems and additional ones that accompany them. There are worrying statistics like one person commits suicide every minute, or suicide rates in particular regions of 8 to 100 for 100,000 inhabitants. Suicide attempts are 10 to 20 times more common than suicides, though both have serious consequences for those who present this behavior.

Different global risk management programs, have demonstrated their efficacy in significantly reducing the incidence and serious consequences of sucide. Relevant and efficient programs prevent psycho-social determinants with primary care for those who present the behavior, using interdisciplinary approaches and family interventions. For example, 60% of people who

commit suicide have a depressive disorder. If processes are created to improve the accessibility and the opportunity of care for the people who suffer from depression, we will impact the most important determinant for this event.

In conclusion, the path is laid out as a model of integral healthcare for different prevalent pathologies, with a good system of referral and counter-referral that uses technologies and strategies to optimize its efficiency. » Quelle: Palacio, Mental health situation in Colombia, Dezember 2018: http://webcache.googleusercontent.com/search?q=cache:aTULtA9UT6YJ:www.scielo.org.co/scielo.php%3Fscript%3Dsci_arttext%26pid%3DS2011-20842018000200006%26lng%3Den%26nrm%3Diso+&cd=2&hl=fr&ct=clnk&gl=ch.

Tamayo-Agudelo & Bell, 2018:

*« **Provision of mental health services is uneven and subject to significant underinvestment. Priority mental health treatment for victims of the conflict is now established in law, although the effectiveness of these programmes has yet to be established**. […]*

*Political debate surrounding the peace process has led to marked social and political polarisation. Key points of disagreement include justice and compensation for those affected by the conflict, integration of increasing numbers of demobilised guerrillas and government response to ongoing violence. **Mental health has become part of this debate because of the direct effects of the conflict on the population as well as the challenges faced by mental health services in Colombia**. […]*

Colombia faces a unique combination of challenges with respect to mental health. Adequate services need to be available to (a) the population as a whole, as they have traditionally had poor access to mental health services and have lived with internationally high levels of systemic violence for many decades; (b) people displaced by the conflict, as they make up almost 15% of the Colombian population and have additional needs but often live in communities with further risk factors for poor mental health and lack of access to support; and (c) individuals with very high exposure to the conflict, as they may have more severe and complex problems that require specialist treatment. This latter group includes civilian victims of violence, torture and other human rights abuses but also includes combatants and ex-combatants from armed groups who need to be reintegrated into society. Combatants may also have been both victims and perpetrators of human rights abuses, leading to complex care needs that involve balancing personal well-being, public protection and political acceptability.

However, uneven availability of services and relatively low levels of investment in mental health and the mental health workforce are still major obstacles (Chaskel et al, 2015). Mental health services are most widely available in urban centres and can be either be absent or sparse in the rural areas most affected by the conflict. Although Colombia provides almost universal healthcare coverage, the current two-tier system provides a markedly poorer level of care for people on the government-subsidised system. In addition, corruption, stalled reforms, health system debts and closure of mental health hospitals and clinics are significant barriers to progress.

One important step has been the development of a national programme that prioritises healthcare for people affected by the conflict, and mental health provision plays a central role in this programme. Law 1448 (2011), passed in 2011, established a programme for social and psychological support for victims of the armed conflict (Programa de atención psicosocial y salud integral a víctimas; PAPSIVI) that is based on the principles of human rights, public health and community psychology. The programme is intended to significantly increase access to mental health services for those affected by the armed conflict, mainly through community physicians, psychologists and social workers.

Although PAPSIVI is a promising and well-designed programme, it is in its early stages and concerns have been raised about slow implementation and future capacity to provide services to millions of people (Sánchez Jaramillo, 2016). Initial concerns about a lack of evidence-based recommendations for interventions and unclear standards for clinicians have been partly addressed by the publication of the 2017 PAPSIVI protocol manual (Protocolo de Atención Integral en Salud con Enfoque Psicosocial a Víctimas del Conflicto Armado) (MinSalud-ITES, 2017). However, a lack of standardised methods for measuring outcome remains a limitation in evaluating the effectiveness of the programme. It is also notable that this protocol has only recently become available and it is not clear to what extent these standards are being successfully implemented in existing teams. » Quelle: Tamayo-Agudelo & Bell, Armed conflict and mental health in Colombia, 2018: www.cambridge.org/core/journals/bjpsych-international/article/armed-conflict-and-mental-health-in-colombia/2E79D2F2088CB6C09713C6111F6C972A.

Zaraza-Morales & Hernández-Holguín, 2015:

« In Colombia, there has traditionally been a model of care focused on the disease, which in the case of people with mental problems has been characterized by the search for diagnosis, treatment and prevention of serious consequences, always with the help of drugs and hospitalization in mental health units. The difficulties of access to mental health services have remained despite the advances in regulations aimed at protecting people with these diseases. Among the best known are the National Mental Health Policy in 1998 and the Law 1616 of Mental Health in 2013. The first one was not implemented, despite its reference point that the development of mental illnesses is linked to context and socioeconomic conditions of persons, and to seek, among other things, to improve the quality of care and comprehensiveness in rehabilitating individuals and communities. Meanwhile, the law has not been regulated after more than two years after its approval. *[…]*

Some studies in Colombia have found that in the case of mental illnesses, discrimination and exclusion presented by the community to people who have been diagnosed with these diseases, even if provided for in the legislation respect and social inclusion of people living in disability, even shown how this situation affects not only the person who has the disease, but their families and the community that shares space with them. *This displays an obstacle for people with mental illnesses to be able to freely access health care services within a community setting, something disturbing especially if what is sought is social inclusion and rehabilitation for people who have mental disease. […]*

In Colombia, there has been some research showing the impact of the constant care of family caregivers of people with mental illness, also highlighting the enormous physical and emotional exhaustion that brings this with the passage of time. Some of them report that the health care system does not provide adequate assistance to their physical ailments, which in most cases arise from these care given. For models of community care, support and coordination established with family caregivers is essential for monitoring the therapeutic processes outlined from the beginning of diagnosis, somewhat visible in models of traditional psychiatric care. […]

Despite normative progress made by Colombia in relation to the mental health of its population, difficulties in access to services remain an obstacle for people with mental illnesses to benefit from quality care. WHO has been emphatic on seeking that health care systems in the world promote social inclusion and create strategies to reduce discrimination and social stigma. However, the few experiences that have arisen regarding community care models in Colombia regarding mental health and the null finding regarding schizophrenia show the ambiguity of the system and evidence the lack of opportunities to implement strategies to shape the truth of the implementation of the strategy for primary care for people with mental diseases*. […]*

Although timidly, in Colombia, services for mental health care are being increasingly recognized, not only because of the problems related to mental health that occur, such as depression and aggressions, but also because of the expectation that generates the recent Law of Mental Health, the focus of Primary Health Care promulgated by the Ministry of Health and Social Protection of the country seeking to ensure the care of people who have such disabilities, improving circumstantially with these actions the quality of life of the whole population. » Quelle: Daniel Ricardo Zaraza-Morales & Dora María Hernández-Holguín, Towards a community mental health care for people with schizophrenia in Colombia, 17. September 2015: www.scielo.br/pdf/csc/v21n8/en_1413-8123-csc-21-08-2607.pdf.

WB & IFC, 17 juillet 2019:

*«[…] Yet****, significant concerns persist about improvements in quality of care not meeting investments and expectations in the sector. A landmark study from The Lancet Global Health Commission on High Quality Health Systems (2018) estimates that over 22,000 Colombians die each year due to poor quality of care, with around another 12,000 dying due to poor access to, or utilization of, services. Although Colombia now provides coverage of healthcare services for a greater share of the population than many other OECD countries (94% to 96% since 2010), health outcomes and quality of care continue to be worse than most other OECD countries.*** *Colombia's maternal mortality rate is higher than all other OECD countries and some 25% higher than that of Mexico, which had the next highest rate. Colombia's years of life lost due to pneumonia (a relatively easily treatable clinical condition) also exceed almost all other OECD countries, except for Lithuania and Mexico. […]*

Mechanisms to verify clinical skills of providers are weak. There is no core standardized curriculum for medical graduates across the country. There are important disparities in human resource distribution, especially in rural and remote parts of the country. ***The current model of care is fragmented. This is an important barrier to quality care for a country where most of the burden of disease comes from non-communicable diseases requiring care integration and coordination to be effective. There is poor communication between pri-***

mary care and specialist services. Patients seek care from multiple providers (e.g. primary care, laboratories, specialty care) in different sites, due to the nature of contracting for different services by health insurance companies. This is an impediment to delivering quality care for an increasing number of patients with multiple chronic conditions*. […]*

Colombia's Social Security System for Health (Sistema General de Seguridad Social en Salud, SGSSS) guarantees citizens universal health coverage through a managed competition design. Citizens belong to one of three insurance mechanisms: the contributory regime (Regimen Contributivo, RC) for employed persons, financed by payroll contributions, the subsidized regime (regimen subsidizado, RS) for low-income or unemployed persons. (MPS, 2004) and the regime for special / exception groups. Citizens in these regimes select a health insurance company (Entidad Promotora de Salud, EPS) to provide services for them, and in theory, exert influence on quality by choosing an EPS that they feel best meets their needs. Health insurance companies, in turn, purchase care from healthcare service providers, such as primary care clinics, hospitals, laboratories and imaging facilities. *Health insurance companies negotiate with healthcare providers on the terms for their contract, reflecting price, volume, and in theory, quality. Territorial entities (Dirección Municipal y Distrital de Salud, DMDS) are responsible for conducting inspections on healthcare providers, and municipalities oversee the quality of public health and health promotion services. Within this complex structure, each accountability relationship must be functioning well, and failure at any level of accountability may decrease in the government's ability to influence change. […]*

Over a period of 25 years since the 1993 health reform ('Ley 100'), ***Colombia has made great strides to reach universal health coverage across its three key dimensions: population coverage, services and financial protection. The Colombian health system provides nearly 95% of its population with health insurance. Service coverage is comprehensive, with a benefits package that excludes only 57 services or technologies for primarily cosmetic or unproven health benefits (MSPS, Resolución 000244, 2019). Financial protection is high, with out-of-pocket expenditures at only 15.5% of the total health expenditures which is very low compared to other Latin American countries.***

However, although Colombia generally provided greater coverage for a larger percentage of the population than many other OECD countries, Colombia's health outcomes continue to fall below its peers. Colombia's life expectancy at birth is lower than all OECD countries except Mexico, Latvia and Lithuania. Colombia's maternal mortality rate in 2016 was higher than all other OECD countries and over 25% than that of Mexico which had the next highest rate. Colombia's years of life lost due to pneumonia also stood above other OECD countries in 2015, with the exception only of Lithuania and Mexico (see Figure 2).

A recent study estimates that, in Colombia, 33,917 deaths per year are attributable to the health care system; of these, 65% (22,080 deaths per year) are due to use of poor quality of care while the other 35% (11,836 deaths per year) are due to non-care utilization or poor access (Kruk, Gage, Arsenault, & Jordan, 2018). *While comparisons with other OECD countries are not available, Colombia is estimated to have fewer deaths per 100,000 population (46) due to poor quality of care compared to Latin American peers like Brazil (74) and Mexico (56). Nonetheless, the numbers are staggering and point to a need for better understanding of quality of care in the country. […]*

Wait times remain comparable to those in many high-income countries but have increased for different medical specialties and remain an issue of concern. Average waiting times have seen a modest increase from 2011 to 2018, for example for general practitioners (from 2.7 to 3.4 days) and gynecologist consultations (2.7 to 10.1). Wait times for pediatric consultations were 8.8 days, for internal medicine 12 days*. Among 5 of 19 OECD countries reporting data, at least one half of residents waited four or more weeks to see a specialist, suggesting an average wait time of at least one month. [...]*

*Available measures for timeliness suggest low availability of specialized care providers in public sector and rural facilities and for departments with higher rates of poverty****. The average waiting time for an appointment with a general physician was slightly higher in public compared to private sector facilities (2.9 vs 2.6 days, 2014 data). Differences in wait times were more pronounced between rural and urban areas, for general physicians (6.4 vs 2.7 days), gynecologists (16.3 vs 8.0 days), general surgery (20.7 vs 14.1 days), and pediatrics (38.8 vs 7.5 days).*** *In 2018, there was a 15-fold difference between departments in the time required to obtain an internal medicine consultation (1 day in Vaupes compared to 15 days in Guainía; see Figure 4). [...]*

Synopsis: Colombia has made progress in reducing hospital infections, vaccinations and outcomes of maternal and child health. There have been modest improvements in patient experience, and wait times are comparable to OECD peers. Yet, ***major gaps in quality remain. Over 22,000 patients were estimated to die from poor quality care in 2016 while 12,000 deaths were attributable to non-utilization or poor access to services.*** *Many evidence-based practices for prenatal care and cancer screening are not well implemented. Variations in quality are common. [...]*

Colombia has made major investments in improving the supply of health human resources; however, the supply of doctors, nurses and hospital beds remains low compared to OECD countries. According to the RETHUS database, the number of doctors has increased by 34% over just six years, to a level of 128,354 as of 2017. Nurses have increased by 47%. Despite these increases****, Colombia has a physician to population ratio of 2.1 per 1000, which is lower than the OECD median of 3.2 and lower than the conservative benchmark of 2.6†. This ratio is, however, comparable to other Latin American countries with similar income levels ‡****. For nursing, Colombia has both nurses and auxiliary nurses (1.26 and 5.16 per 1000) but relies more on the latter compared to other countries. When both types of nurses are grouped together, the total nursing professional to population ratio again is in the lower end of OECD countries (benchmark 8 per 1000)§. Hospital bed capacity, at 1.7 beds per 1,000, is also at the lower end of OECD countries and lower than the benchmark of 2.5. ** [...]*

Availability of medications is generally good and is guaranteed by law. The Constitution of 1991 guarantees universal health coverage for essential medicines. There is a standard benefit plan which defines drugs and services which providers should offer; medicines, services and technologies that are not in the benefit plan may still be provided through the MIPRES tool(MSPS, 2017*). Regulation 1751 of 2015 (Congreso de Colombia, 2015) confirms that drugs will be provided, except those lacking in clinical evidence of effectiveness or safety. One issue noted in this regulation is that there is a national mechanism for setting prices of drugs, for cost containment purposes. Although most site visit interviewees did not raise concerns about drug availability, some did report occasional shortages of basic*

drugs such as oxytocin or lidocaine; it is not clear if this is a supply chain issue or due to the price being set too low to attract reliable suppliers. […]

Staff interviewed cited numerous problems with the current model of care, such as poor communication between primary care and other sectors. Interviewees noted that when patients are sent to a specialist, other health workers (e.g. dietician or mental health), or admitted to hospital, information about the visit is not sent back to the primary care physician*. Some exceptions were noted; accredited hospitals generally provided information about treatment plans, and information on pregnancy care is usually provided. Also, in some cases a patient is provided with a summary of the diagnosis and treatment plan. If the patient brings this to the visit, then the doctor is aware, but this does not always happen. In general, specialists and primary care doctors work in separate locations, do not share records and cannot see each other's health information. One exception was a network in Bogota which had visiting specialists within a primary care clinic, who could access the same EMR. Joint case management of patients with difficult-to-treat medical conditions generally does not occur. […]*

Synopsis: Colombia has a supply of human resources and hospital infrastructure comparable to middle-income South American countries but less than typical OECD countries. There are concerns about the system's ability to ensure staff have appropriate clinical skills. Existing resources are not used optimally; health professionals are concentrated in urban regions like Bogota, and problems with the model of care delivery need to be addressed, including poor coordination and a disjointed patient journey due in part to the way the health insurance companies contract their services. […]

The Colombian General System of Social Security in Health (Sistema General de Seguridad Social en Salud, SGSSS) provides almost universal insurance coverage. Colombia's constitution was amended in 1991 to ensure that access to health care was a universal right for its residents. The health reform of 1993 (Ley 100) and the subsequent Sentence T760 of 2008 that called for the equalization of the right to health for all residents, provides the legal basis for a commitment to Universal Health Coverage. Central to the design of the health system, to achieve this aim, is the expectation of quality of care whereby all residents, given the right to health care are ensured a capitated payment to their insurer of choice that is to be selected on the citizens' perception of quality of care to be received. Since 1993, the proportion of the population with some form of coverage has increased to 95% (OECD, 2016). In addition, out-of-pocket expenditure as a percentage of current health expenditure declined from an estimated 44% in 1993 to less than 20% in 2016, significantly lower than the Latin American average of over 30%.

In addition to the legal basis of the right to health defined in the constitution and health reform in the early 1990's, Colombia has established a system of judicial claims to ensure the right to access and quality of health services*. Among Latin American countries, Colombia stands in similar ranking to Brazil, with the highest number of judicial claims (tutelas) filed by residents who primarily demand access to specialist health services and timeliness in the receipt of services. Although system of judicial claims (tutelas) is currently backlogged and responses are often delayed, the continued policy of its use continues to assure residents of the country of their right to health and quality of services.»* Quelle: World Bank & International Finance Corporation (IFC), External Assessment of Quality of Care in the Health Sector in

Colombia, 17. Juli 2019, S.7-8, 20, 25, 27, 29, 31, 42-45, 52: https://openknowledge.worldbank.org/bitstream/handle/10986/32281/External-Assessment-of-Quality-of-Care-in-the-Health-Sector-in-Colombia.pdf?sequence=1&isAllowed=y.