



Gender equity and health sector reform in Colombia: Mixed state-market model yields mixed results[☆]

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ABSTRACT

In 1993, Colombia carried out a sweeping health reform that sought to dramatically increase health insurance coverage and reduce state involvement in health provision by creating a unitary state-supervised health system in which private entities are the main insurers and health service providers. Using a quantitative comparison of household survey data and an analysis of the content of the reforms, we evaluate the effects of Colombia's health reforms on gender equity. We find that several aspects of these reforms hold promise for greater gender equity, such as the resulting increase in women's health insurance coverage. However, the reforms have not achieved gender equity due to the persistence of fees which discriminate against women and the introduction of a two-tier health system in which women heads of household and the poor are concentrated in a lower quality health system.

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On December 23, 1993, Colombia passed Law 100 on Social Security Reform which constituted a sweeping national health and pension reform. The health reforms of Law 100 were hailed by the World Bank and the World Health Organization as an international model (Escobar, 2005; Hsiao, 1998; WHO, 2000). Unlike its regional forerunner, Chile, which utilized primarily market mechanisms in its health reform of 1979, Colombia utilized a combination of market mechanisms and state intervention. Colombia's "managed competition" approach pairs the belief that market competition will increase efficiency with the belief that government regulation is necessary to ensure equity. Since 1993, Colombia's managed competition has been a reference point for health reformers across Latin America: Mexico, the Dominican Republic and Chile in its recent re-reforms each used Colombia as a starting point for their own reforms. Although revered by some, others have questioned the effectiveness and equity of the reforms (e.g. De Groote, De Paepe, & Unger, 2005; Fresneda, 2002; Fresneda & Martínez, 2002; Homedes & Ugalde, 2005; Restrepo, 2002; Ruiz, 2005).

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We examine the effects that the Colombian reforms have had on gender equity, with an emphasis on women. Given the international attention to Colombia's health reforms, their effects on gender equity beg for analysis. Existing empirical studies of gender equity and health sector reform suggest that market-oriented health reforms tend to create or intensify gender inequities. For example, market reforms attempt to reduce the costs of health care by transferring a greater share of health care provision from state or private providers to individuals and especially women within families as a result of shorter hospital stays or greater reliance on home-based primary care (Ewig, 2006). Markets also tend to view women as higher "risks" due to their reproductive health needs and related greater health care usage rates (Forget, Deber, Roos, & Walld, 2005). Private insurance systems, as has been shown in Chile, tend to shift the financial cost of childbirth and reproductive health care directly to women, thus making women pay disproportionately for society's human reproduction (Ewig, 2008; Gómez, 2002; Pollack, 2002). Moreover, in systems organized around an individual's capacity to pay, women are the least likely to be covered by health insurance and the least likely to be able to pay fees for health services – reflecting broader patterns of gender discrimination in labor markets, women's greater levels of poverty, and intra-familial power dynamics (Ewig, 2006; Nanda, 2002; OPS, 2002). The Colombian reforms, which mix market incentives with state regulation, would seem to offer promise for greater gender equity than purely market-oriented systems.

Defining and measuring gender equity in health

Gender equity in health includes biological and social dimensions (Doyal, 2000). Whereas equality assumes sameness, the concept of equity recognizes the “differences in needs, conditions, perspectives and experiences that characterize differently situated social groups” (Petchesky, 2003, p. 169). While in many instances equality is desired, equal outcomes cannot be expected in the realm of health, where biological differences between men and women lead to different health outcomes. We are attentive to how reforms may affect access to services related to sex, such as specific biological health needs, and how reforms may interact with socially constructed gender inequities, such as women’s poverty and unequal parenting responsibilities. As Amartya Sen (2002) argues, equity in health is not a question of health results, nor is it solely a question of distribution of services, equity encompasses all the conditions that allow for the possibility to achieve good health. The gender equity of a health system, therefore, cannot be measured by comparing male and female usage rates nor by comparing male and female health outcomes, rather it must be measured by the degree to which health systems create the conditions for achieving good health.

We limit our discussion to three dimensions of gender equity and health: whether reforms have increased *financial equity* between men and women in bearing the burden of health care costs; whether the health system responds to *women’s health needs*; and the effect of reforms on *gender stratification*, meaning whether health policies create or reinforce stratification between men and women by offering each different benefits or benefits of differing quality.

In our analysis of financial equity, we focus on the financing structure of the Colombian health system, insurance coverage, and out of pocket costs. In addition to qualitative analysis of financing structures, we use two quantitative sources to measure change in financial equity: the 1993 Colombian Socioeconomic Survey (CASEN) and the 2003 Colombian Quality of Life Survey (ECV). For the pre-reform period, we draw on the 1993 CASEN. The CASEN is based on a representative rural and urban sample of each department and the principle cities of Colombia and includes a total of 27,271 homes. Given that the reforms were not implemented until 1994, the CASEN study provides a snapshot of before reforms. The CASEN has fewer questions but includes several comparable to those in the 2003 ECV. The 2003 ECV, conducted 9 years after the implementation of reforms, provides a good marker of post-reform Colombia. The ECV is a national survey carried out through direct interviews with adult household members covering all the principle rural and urban areas of Colombia. The 2003 survey included a total of 22,949 households and 85,150 individuals. The survey uses the World Bank Living Standards Measurement Survey methods to measure quality of life including health utilization, health and social security coverage, and perceptions of health care quality.

We also use the 2003 survey to assess the effect of the reforms on gender stratification; we analyze concentrations of women compared to men in the contributory and subsidized systems that resulted from the reform and stratification among women to determine which women have the best and worst health benefits.

Finally, through evaluation of plan content, we assess whether Colombia’s reformed health system serves the specific health needs of women. Industrial and developing countries alike have attempted to achieve health care cost savings by guaranteeing only a basic package of services. The Colombian reform adopted this approach, with plan elements chosen based on cost-effectiveness.

The 1993 Colombian reform

Colombia’s previous health system, in place since 1975, was characterized by a lack of coverage and solidarity. This system was composed of three sectors. The social security sector guaranteed health care to formal sector workers but never covered more than 25% of the population and covered less than 50% of salaried workers. The private sector served the highest economic strata, about 10% of the population. The state public health system served the poor – but reached barely 40% of the population. About 25% of poorest Colombians in the most isolated regions had no access to health services (OPS, 1995). Public health services were supposed to be free of charge, but in practice often charged fees and thus were inaccessible to many (Plaza, Barona, & Hearst, 2001).

Law 100 of 1993 dismantled the previous system and created in its place the General System of Health Social Security. The first in Latin America to combine market principles and state regulation, this reform was heavily influenced by the World Bank which viewed a combination of market and state mechanisms as the best strategy to reduce state spending and simultaneously fight poverty (Hernández & Vega, 2001; OPS, 1995; World Bank, 1993). The reform also stemmed from national politics, in particular the new Colombian Constitution, ratified in 1991. Written in a participatory process that departed from Colombia’s exclusionary political traditions, the new Constitution was ground-breaking. Significant for the health sector, it declared social security a right which was to become progressively universal and obligatory. While the Constitution signaled greater solidarity, its implementation was up to the government of President César Gaviria who sought to introduce neoliberal principles into the Colombian economy (Ahumada, 1996; González-Rossetti & Ramírez, 2000). The tension between the solidarity promoted by the Constitution and the market-driven principles supported by the Gaviria government and international financial institutions helps to explain why Colombia opted for a managed health care model combining state and market elements. Among reformers in Latin America, Colombia comes closest to the “structured pluralism” model of health delivery developed by Juan Luis Londoño and Julio Frenk (1997), key figures in Colombia’s reform process.

The health reform also took place on the heels of a decade of change for women. Colombia’s women’s movement had been active throughout the 1980s, culminating in a series of political gains in the early 1990s. In 1990, a Presidential Council on Youth, Women and the Family was established to “mainstream” gender into Colombian policy (Beall, 1998). Feminists were also active in shaping the 1991 Constitution, which declared equality between men and women, family violence unconstitutional, and special protections for pregnant women and female heads of household. In addition, women for a brief time gained a national quota law for elected office (from 2000 to 2003). In the health arena, feminists were focused on reproductive health, eventually succeeding in getting the Ministry of Health in 1992 to adopt a plan to address women’s needs including occupational health, violence, mental health and reproductive health (Plata, González, & de la Espriella, 1995). Feminists also struggled to legalize emergency contraception and therapeutic abortion. Yet, gender equity was not a point of discussion among policy-makers or feminists with regard to the 1993 health reform. This was despite the fact that the health status of women in Colombia in 1993 was exceedingly poor – one study found 94% of Colombian women to be in poor or deficient health (Sánchez, 1998). Even as the reform unfolded, attention to gender equity was minimal, in contrast to Chile, Mexico, Peru, and Ecuador where there were efforts by women activists or the gender unit of the Pan American Health Organization to integrate gender equity into more recent health initiatives (Ewig, 2008; Langer & Catino, 2006).

The key health components of Law 100 were: individual insurance, regulated competition between health providers, consumer choice, state subsidies for the poorest, and a guarantee to benefits contained in a package of services determined by the state. Although the Constitution required the creation of a universal insurance system, as the reform progressed through its regulatory phase beneficiaries were divided into two groups served by separate health regimes: contributory beneficiaries (those with ability to pay) and subsidized beneficiaries (the poor). Another group remains uninsured, some of whom are poor and use the public system, others of whom are wealthy enough to pay for health care privately. Although insurers initially were supposed to serve both regimes, due to profitability concerns insurers divided into two groups: one serving the contributory regime and the other the subsidized regime. Beneficiaries of the subsidized regime are selected based on the Selection System of Beneficiaries for Social Programs (SISBEN, *Sistema de Selección de Beneficiarios para Programas Sociales*), a targeting instrument designed to identify the poorest and most vulnerable, including pregnant women and female-headed households. SISBEN beneficiaries are eligible for a number of state benefits, including subsidized health care. SISBEN beneficiaries are further divided into six socioeconomic levels (one the poorest and six the best off) with benefits dependent on level and only levels one through three eligible for benefits.

The funding mechanisms for the two regimes also differ. While initially employees contributed 12%, with the passage of Law 1122 in January 2007, employees now contribute 12.5% of their salary which serves to finance the contributory system (75% paid by the employer, 25% paid by the employee. Independent workers pay 100%). The subsidized regime, originally financed by a 1% cross-subsidy tax on salaried workers, is now financed by a 1.5% cross-subsidy and national and local government funding. These funds are managed by the state solidarity fund and are distributed to insurers based upon a risk-adjusted per capita capitation fee. The capitation fee is roughly equivalent to the value of the health package and its administrative costs. The fee was designed to avert adverse selection by providing higher compensation for higher risk clients, factoring in age, sex and geographic area to account for the higher costs of the elderly, women of reproductive age and distant clients.

Insurers administrate funds while health providers provide the health care services. The insurers are required to provide a package of services that are outlined in the Obligatory Health Plan, for which there are two separate plans, one for the contributory and one for the subsidized regime. During the reform process a contentious debate ensued between some private insurers, doctors, unions, Left party members and some Liberal Party members who favored identical packages for the two regimes, and the Ministry of Health (heavily influenced by the World Bank) and other private insurers who argued for a plan focused on basic services for the subsidized regime due to fiscal constraints. The latter won and separate packages were established (Ramírez, 2004). Law 100 dictated a period of adjustment until the year 2001, by which time the entire population was to be guaranteed insurance in one of the two regimes and the plans were to be equalized.

The timeline for the transition period was based on expectations of continued economic growth including salaried jobs. However, the economy did not grow at the expected rate: in 1993, it grew at rate of less than 3% and unemployment grew to over 7.8% (5.3% among men and 11% among women) (DANE, 2002). By 2002, unemployment had reached 18.0% (DANE, 2002), with a related rise in the informal sector, from about 35% of the working population in 1993 to just over 40% in 2003. Women continue to be over-represented among the unemployed and working women are disproportionately in the informal sector (Cárdenas & Mejía, 2007).

In the same period, total spending on health care increased from 6.2% of GDP in 1993 to 7.8% in 2003 (Barón Leguizamón, 2007). As a result, the goal of universal and uniform insurance coverage has not been met.

Results of analysis

Financial equity

Three aspects of the Colombian reforms would suggest improved financial gender equity: the incorporation of dependents, the percent of salary financing mechanism, and the creation of a subsidized system for the poor which also targets pregnant women and female-headed households. Law 100 dictated that the state system provide complete health insurance to dependents. Prior to this, only the state social security institute provided dependent coverage and it only covered obstetric care for spouses and health care for children under age one. While women have increased their workforce participation over time (55.2% of urban women were in wage work in 2006 compared to 49.8% in 1998) more than half of these working women are concentrated in the informal sector and thus not eligible for the contributory regime. In 2006, formal sector wage earners accounted for just 46.6% of all women workers (compared to 51.5% of male workers) down from 58.7% in 1998 (CEPAL, 1999, p. 23, 36; CEPAL, 2007, p. 40, 52, 53). Expansion of dependent coverage with Law 100 should have led to a significant increase in women's coverage by incorporating women who were not employed in the formal sector but whose spouses were.

Our analysis of survey data shows that insurance coverage for dependents led to substantial increases in health care coverage in general and for women in particular. In 1993, prior to the reforms, only 24.5% of the surveyed population possessed some form of health insurance and coverage rates for men and women, surprisingly, were about the same despite a lack of mandate to cover dependents and women's lower levels of formal sector employment. After reforms, Colombia saw a marked improvement in health insurance coverage and a greater increase for women compared to men. In the 2003 survey, 66.2% of men and 71.3% of women had some form of health insurance (Table 1). Dependent coverage accounts for some of this increase: the percent of women dependents covered rose to 25.2% and men's coverage as dependents to 12.9%. Women previously covered as dependents also gained in that they were now eligible for general health services, not just obstetric services.

However, the concentration of women as dependents places women in greater proportion in a more precarious form of health insurance. Dependent coverage is more precarious than coverage gained by employment or coverage as a citizenship right (as in the universal health care systems of Europe or Canada) because it depends upon the good graces of the marriage partner or parent. If dependent relationships become strained or dissolve, or if the contributing partner loses work or dies, dependents may lose their rights to health care as well.

The second aspect that boded well for women's economic equity was the reform's percent of salary financing mechanism. In contrast to Chile, where a significant sector of the population pays on an individual basis with payments determined by individual "risk", in Colombia all formal sector workers pay the same percentage of their salary. By paying by percentage, risk is pooled rather than individualized. Women benefit from this system in two ways: first, women throughout their reproductive years are categorized by health insurers as higher risk than men due to their potential to bear children and its associated medical costs. In Colombia, male and female workers pay the same percentage of their salary to their

Table 1
Sex and insurance affiliation before and after reforms.

	1993, Before reform				2003, After reform				
	Direct affiliate	Dependent	No health insurance	Total	Direct affiliate contributory regime*	Dependent contributory regime	Subsidized regime	No health insurance	Total
Men	21.5%	2.5%	76%	100%	35.8%	12.9%	17.5%	33.8%	100%
Women	12.7%	11.8%	75.5%	100%	26.3%	25.2%	19.8%	28.7%	100%
Total	16.8%	7.7%	75.5%	100%	30.7%	19.5%	18.8%	31.0%	100%

Source: CASEN-93, *N* = 53,837. Includes adults over age 17.

Source: ECV-03, *N* = 55,105. Includes adults over age 17.

*Includes Social Security and Private Insurance.

insurer, and the state compensatory fund in turn pays insurers additional differential sums based on pre-determined risk factors. Thus, the system pools the responsibility for the medical costs of human reproduction. Second, by paying a percentage of salary rather than a pre-determined cost, women pay for health care relative to their earnings, which tend to be lower than men's, compensating to some degree for labor market gender discrimination.

The SISBEN instrument which determines eligibility for the subsidized health regime prioritizes pregnant women, children under 5 years of age, the disabled, displaced people, women heads of household, the elderly, and the rural, indigenous and poor urban population. Consequently, the creation of the subsidized regime had the potential to reduce gender inequities by providing vulnerable groups of women access to health care. Although women are not poorer than men in Colombia, women-headed households are concentrated among the poor. In 1997, 25.8% of Colombian households were headed by women, growing to 31.8% in 2003. In 2002, 19.9% of these households were in poverty. By contrast, only 6.9% of male-headed households were in poverty in 2002 (DANE, 2003). When the value of health care is calculated as income, Colombia's reform has been shown to be redistributive, with those in the subsidized regime gaining the most (Flores et al., 2007, p. 70). We expect this redistribution also benefits the single female-headed households that are concentrated in the subsidized regime.

The SISBEN has contributed to women's higher insurance coverage than men's. After reforms, 17% of men and 19% of women obtained coverage through the subsidized system (Table 1). Increased coverage also appears to have led to greater utilization rates for some key services, such as prenatal and birthing care. Between 2000 and 2005, the use of these services by women in the subsidized regime grew by 7.4% for prenatal and 9.7% for birthing care, though their utilization rates of these services still trail those of women in the contributory regime by more than 10% (Flores et al., 2007, pp. 30–31).

Insurance may improve the likelihood of access to health care, and it has improved utilization rates of some services, but it does not guarantee access or equity. Out of pocket costs can still pose a financial barrier even with insurance, and may be inequitable between men and women. Before the reforms, the vast majority had high out of pocket expenses, and women were subject to these expenses significantly more than men: 69.2% of women who were hospitalized paid for at least a portion of their care out of pocket, compared to 57.4% of hospitalized men (CASEN-93, *N* = 3,493, *p* = 0.000). These high rates of out of pocket fees may have contributed to a lack of access to care. While reforms have reduced out of pocket payments by providing broader insurance coverage, fees have not been eliminated; 2.3% of men and 3.8% of women who were hospitalized in 2003 reported using at least some personal or family resources for payments (ECV-03, *N* = 55,105, *p* = 0.000). The reformed system encourages percentage-based fees as a means of

reducing demand for "unnecessary" services and controlling costs. For affiliates of the subsidized regime at income level 1 the value of the co-payment is 5% of the cost of care; at income level 2 it is 10%, and it is 30% for those at income level 3. While a sliding scale, ambulatory services may be more accessible than more expensive hospital services, for which even a 5% fee may represent a costly burden.

This burden is illustrated in the numbers that report not seeking care when sick. Despite the dramatic increase in health insurance coverage, 20.8% of adults who reported being sick and in need of care, did not seek professional care, a number that is not dramatically lower than the previously mentioned 25% that could not access health care prior to the reforms (ECV-03, *N* = 5303). Reasons for not seeking care vary by gender, with men more often citing lack of time – 15.1% of men compared to 8% of women. However, the greatest reason for not seeking care was lack of money – 53.8% of men and 56.5% of women cite this reason (ECV-03, *N* = 1102, *p* = 0.004). We find that lack of money is especially burdensome for single female heads of household, independent of poverty. Insurance coverage, however, significantly alleviates this burden. Table 2 presents a binary logistic regression which assesses why individuals cite lack of funds for not seeking health care when sick. The model provides pooled data and because of the large effect of insurance, we also split the data into those with and without insurance. Among those with insurance, poverty is the only significant factor that leads individuals to not seek care when sick due to lack of funds. Among those without insurance, however, poverty and single female household headship are significant factors, indicating the importance of insurance coverage for addressing gender-related financial inequities.¹

Yet, insurance coverage does not eliminate financial inequities between women and men. Compounding the financial barrier for female-headed households is the fact that all women – insured and uninsured – are paying for health care out of pocket more often than men. This is the case both before and after reforms. Above, we gave the differences between male and female rates of paying out of pocket for hospitalizations in 1993 and 2003. For ambulatory care as well, across income quintiles in 2003, between 6.3 and 7.1% of women use some out of pocket resources for their health care costs, rates consistently and significantly greater than those of men, which range from 4.2% to 5.6% depending on quintile (ECV-03, *N* = 54,945, *p* = 0.000). While amount paid per visit by rich and poor is relatively similar (the majority pay between 1 and 39,999 Colombian pesos, equivalent to between 1 and 17 U.S. dollars), the poor cite paying the more frequent lower fees more often than the wealthy. The poorest quintile reports paying fees in this range 71.2% of the time, whereas the richest quintile reports paying fees in this range 58.4% of the time (ECV-03, *N* = 1,629,379). Although low,

¹ Figures in this paragraph exclude those whose sickness was minor and for that reason did not seek care. Includes those over age 17.

Table 2

Likelihood of not seeking care due to lack of money, 2003. Estimates of odds ratios, binary logistic regression.

Independent variables	Insured		Uninsured		Pooled	
	Odds ratio	% Change in odds	Odds ratio	% Change in odds	Odds ratio	% Change in odds
Single female household head	1.258	26	2.180****	118	1.637***	64
Single male household head	1.506	51	1.359	36	1.333	33
Married/cohabitating female head	1.327	33	1.008	0.8	1.133	13
Number of children in household 17 or under	0.951	−4.9	1.070	7	1.019	2
Quintile 1 (poorest)	14.851*	1385	2.761	176	5.490*	449
Quintile 2 (very poor)	5.543**	454	2.606	160	3.403*	240
Quintile 3 (poor)	8.838*	783	0.909	−9.1	2.103**	110
Quintile 4 (middle)	4.571**	357	1.512	51	2.283**	128
Lacks insurance	–	–	–	–	7.581*	658
Sample size		458		630		1088
Chi-square	(d.f. = 8)	498.402	(d.f. = 8)	676.684	(d.f. = 9)	199.517
Cox & Snell R ²		0.100		0.054		0.239
Nagelkerke R ²		0.143		0.080		0.320

* $p = 0.000$, ** $p \leq 0.006$, *** $p = 0.014$, **** $p = 0.020$.

Did not seek care due to lack of money = 1, did not seek care for another reason = 0.

Includes adults over age 17. Excludes those with minor ailment and for that reason did not seek care. ECV-03.

such fees hurt the poor more, including the female-headed households concentrated among the poor, due to their lower incomes.

The gender differential in fees raises two important issues, one sex-related and one gender-related. Because women use health care more frequently than men – due to higher rates of morbidity and the need to access reproductive health care more often – out of pocket expenses fall disproportionately on women due to their biological health needs. While men and women pay about the same amount per visit, because women have more visits and because they more often cite being charged out of pocket fees, their costs are also higher. Gómez reports that for Colombia, women use health services between 5.2 and 6.5% more than men do dependent on income quintile, thus they are likely to pay fees at least this much more often (Gómez, 2002). Second, fees for their own and for child health services may come disproportionately from women's pockets rather than men's or pooled family resources, due to gendered societal norms. We do not know of intra-household asset studies for Colombia, however, evidence from other Latin American countries indicates that families do not always pool incomes and that women are more likely than men to spend the cash that they control on child well-being, including child health care (Roldan, 1988; Thomas, 1997; Yoshioka, 2006). Fees, therefore, are more likely to financially impact women.

Gender stratification

Our analysis of the reforms for their effects on gender-based stratification shows negative results for gender equity. The new system is segmented into the old state system and two forms of private providers, those serving the contributory regime and those serving the subsidized regime. Above, we provided evidence that females are more likely to be in the subsidized regime, a logical outcome given female-headed households are prioritized for inclusion in this regime. Controlling for income, we find that among women, single women-headed households are 12.4% more likely than other types of families to be in the subsidized regime (ECV-03, $N = 54,945$, odds ratio 1.124, $p = 0.003$).² In other words, although women have overall higher rates of coverage compared to men, single women-headed households are concentrated in the lower

tiers of insurance providers which provide lesser quality of care and fewer services.

In addition to the stratification between male and female-headed households, among women, certain groups of women are more likely to lack coverage altogether. Afro-descendent Colombians and those displaced by Colombia's civil war are least likely to have health insurance. Among Afro-descendents, 53.9% have no health care coverage, compared to 32.9% non-coverage for the population as a whole (ECV-03, $N = 85,150$).³ Afro-descendent women are better off than Afro-descendent men (more Afro-descendent men (55.2%) than women (52.6%) lack coverage); consistent with the overall greater levels of women's insurance coverage in Colombia, post-reform (ECV-03, $N = 5602$). Yet, compared to the population as a whole and other woman, Afro-descendent women face a severe lack of access to health insurance. This lack of coverage indicates the lack of health resources directed to the regions most populated by Afro-Colombians as well as the high concentrations of Afro-Colombians among those displaced by Colombia's political violence. The displaced are primarily women and children and one of every four is indigenous or Afro-Colombian. Among displaced women, 58% lack coverage, compared to 38.5% of women in the communities that receive them (Ojeda & Murad, 2001). A major reason behind the lack of coverage of this group is the lack of portability of insurance, as displacement effectively means loss of coverage.

Women's health needs

The 1993 reforms established two separate "obligatory health plans" – one for the contributory and one for the subsidized regime. The wealthy commonly augment the package provided by the contributory plan through private, supplemental insurance. Although both plans guarantee care for pregnant women and children under 1 year of age, the plan for the subsidized regime provides fewer benefits than the contributory. Initially, it only provided 50% of services provided in the contributory plan at the secondary level. It now includes high cost services, but excludes most diagnostic procedures and most services that require hospitalizations or medium complexity surgery.

² Binary logistic regression not shown.³ We combined "Palenquero" and "Afro-descendiente" into one category as both are Colombians of African origin.

The differences between plans are crystallized in the value of the risk-adjusted payment paid by the compensatory health fund to insurers. In 2008, the value of the capitation fee for the contributory regime was \$404,215 Colombian pesos and the capitation fee for the subsidized regime was valued at only \$242,370 Colombian pesos – 40% less (Consejo Nacional de Seguridad Social en Salud, 2006, 2007, 2008a). Although they do not reflect the exact value of the benefits received, the figures provide a general indicator of the inequities that exist between the regimes, in which some are afforded more expensive coverage than others. As already discussed, the poor and single women-headed households are concentrated in the subsidized system. The difference in capitation fee values, therefore, implies an important gender inequity.

The difference in quality between the two systems is large, with the subsidized system providing inferior care. From a gender equity perspective, one indicator of the low quality of the subsidized regime is the fact that maternal mortality rates are concentrated in this regime. We use figures from the post-1997 period, after a change in maternal mortality data collection practices took place. Over the 9-year period of 1998–2006, the rate of maternal mortality in the subsidized regime averages twice that of the contributory regime (DANE, 2008). The concentration of maternal mortality in the subsidized regime suggests problems with quality because the primary causes of maternal death are preventable.

Raising ethical concerns, the obligatory plan of the subsidized regime does not cover several specific women's health needs that are covered in the contributory system. For example, while women in the contributory system receive salary coverage for maternity leave and sick pay, these are not offered to women in the subsidized regime. In addition, mammograms are included in the contributory regime, but not the subsidized regime, which has led to great gaps in usage rates. In 2005, 51% of women in the contributory regime received a mammogram compared to 12% in the subsidized regime. Even those without insurance received mammograms more often (16%) (Flores et al., 2007, p. 30). More disturbing, despite the fact that cervical cancer is the leading cause of morbidity and mortality among women in Colombia (Pineros, Hernández, & Bray, 2004), it was only 12 years after the initial reform that the subsidized regime offered complete cervical cancer diagnostic services. While the subsidized regime initially covered the simple check for cervical cancer, if the test came back positive, up until 2005, it did not cover the colposcopy and biopsy necessary to confirm the test (Consejo Nacional de Seguridad Social en Salud, 2005). In order to receive these diagnostic services, subsidized plan affiliates reverted to uninsured and pursued these services through the public system of last resort. Once the cancer was confirmed, they returned to the subsidized system for treatment. The danger of this complex process was that in the time that women found the means to cover the interim steps, the disease progressed and became more life-threatening and costly to treat. Finally, it was only in 2008 that oral contraceptives and condoms were included in both the contributory and subsidized regimes (Consejo Nacional de Seguridad Social en Salud, 2008b). These exclusions of key women's health needs are unethical in that they deny crucial care to poor women, putting these women's lives at risk.

Some affiliates have pressed through the courts for their Constitutionally guaranteed right to health care to be upheld when services have not been included in the obligatory plan (or have been denied coverage by insurers despite inclusion). In these instances, affiliates have filed cases with Colombia's Constitutional Courts and demanded that their insurer cover needed medical treatments. A study completed by Colombia's Human Rights Ombud's office revealed that 26% of all cases brought before the Constitutional Courts between 1999 and 2003 were health related, and 70% of these were claims for services guaranteed by the

obligatory plan but which had been denied by the insurer. Among claims for medical procedures, biopsies and gynecological procedures were the fifth and sixth most commonly claimed procedures (Defensoría del Pueblo, 2004). While the study does not analyze the sex or socioeconomic status of claimants, it is logical that the poorest (among these, female heads of household) and least educated will be less likely to file a court claim and will be even less likely to attain services. In fact, a majority of the health claims (70%) are filed by affiliates of the contributory regime and 20% from the subsidized regime, a reflection of the income and information disparities between these groups rather than an indicator of lesser quality of the contributory regime (Superintendencia Nacional de Salud, 2007).

More positively, the Constitutional Court ruling in May 2006 to liberalize Colombian abortion law has led to the inclusion of abortion under specific circumstances in both the contributory and subsidized health regimes. When the health reforms were first passed, abortion was illegal under any circumstance, denying an important women's health need. After decades of pressure, national feminist groups and the international organization, Women's Link Worldwide, used international human rights law to successfully argue for abortion liberalization. Abortion is now legal when it presents a risk to the life or health of the woman, when the fetus is seriously malformed or unviable, or when the pregnancy is the result of a criminal act. Medical practitioners may not deny abortion services under these circumstances. Subsequent to the ruling, the Colombian Ministry of Health included abortion in both the subsidized and contributory regimes, offering three methods of abortion by December of 2006, though implementation has been fraught due to providers' resistance (Vieira, 2008). Prior to this, in 2000, the Ministry of Health also included emergency contraception in the package of family planning options available to women, despite active opposition by the Catholic Church and conservative groups (Profamilia, n.d.).

Finally, while wealthy women have the best access to health care due to their ability to pay, they are not immune to discrimination. Private supplementary insurance policies charge women of reproductive age more than men. For example, in 2006, the private insurance company Humana charged females of reproductive age (15–44 years) 1.68 times the rate that it charged its male clients of the same age in its "Preferential Plan 3000". It also charged women age 25–54, 1.53 times its charged for males of the same age in its "Plan Plus". Similarly, Colpatria charged women between the ages of 25 and 34 twice what it charged men of the same age for its "Alterno" plan, and 2.08 times that of men in its "Original" plan. Cafesalud, for its part, charged males and females the same, but had a surcharge for obstetric services (authors' calculations from Superintendencia Nacional de Salud, 2006). Thus, although the wealthiest women have access to the fullest range and highest quality services, key women's health needs, such as pregnancy, are only covered at significantly higher cost.

Conclusion

The impact on gender equity of Colombia's mixed market-state health care model is quite mixed. In terms of financial equity, there has been an improvement in insurance coverage as a result of reform, a change which has benefited women. In addition, Colombia's insurance financing system partially pools payments and health care costs, which is more gender equitable than purely individual payment systems. Yet, co-pays, which also form part of the reforms, discriminate against women who have a lesser capacity to pay combined with greater health needs. In addition, the fragmentation of the Colombian health system into a system for those who can pay (the contributory system) and those who cannot

(the subsidized system) has led to stratification between men and women where women are concentrated in the lesser-quality subsidized health system. Among women, we find marked differences in insurance coverage dependent on race, class, and displacement by Colombia's armed conflict. Finally, motivated by cost-control, the subsidized system does not provide for key women's health needs.

The more market-oriented elements of the Colombian reforms: the fees for services which are intended to discourage "over usage" of the health services; attempts at cost savings by restricting services to a pre-determined package; and the lack of regulation of the private supplemental insurance industry are those areas where gender inequities are most evident. In addition, the creation of two separate but unequal health care regimes – the result of cost-saving politics which worked against the original intent of the Constitution – has led to inequitable gender stratification in which women are concentrated in the poorer quality subsidized regime which does not address important women's health needs. The more rights-based aspects of the reforms, such as the goal, codified in the Constitution, of offering health insurance to all Colombians, the establishment of the compensation fund to pool risk among those insured in the state systems, and the Constitutional Court's decision to liberalize abortion, have been positive steps toward greater gender equity.

The Colombian reforms, overall, hold promise for creating gender equity in health, but as of yet have not met this potential. In particular, meeting the original reform goals of universal coverage and a unified package of services for the contributory and subsidized regimes, including all women's health needs (such as mammograms) would be significant steps forward. Elimination of co-pays, minimally in the subsidized regime, would also promote greater gender equity. Finally, the system requires greater government oversight to ensure equity in quality between the two regimes; to ensure that insurers actually provide all that is guaranteed in the basic package; and to prevent the discriminatory fees that are now imposed on women who purchase supplemental insurance.

A potential way forward toward greater gender equity would be to argue for these changes through the Constitutional Court, given that the right to health, equality between men and women, and preference for female heads of household, are guaranteed in the Constitution. In August of 2008, the Constitutional Court, with sentence T-760, ordered that the government unify the benefits packages and guarantee universal coverage by January of 2010. The sentence, however, does not clearly recognize gender inequity, nor age, ethnic or class inequities related to health. A clear recognition by the Court of these, and positive action by the government to guarantee the right to health for all, would be one way to address these issues.

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