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# **Advocacy coalitions, contestation and policy stasis: the twenty-year reform process of the Colombian health system.**

## **Abstract**

This article analyses the 20-year long process of health system reform in Colombia using the advocacy coalition framework (ACF). Since its inception in 1993, the basic organising principles and structures of the Colombian health system have remained highly contested. Despite this, the system brought into effect by Law 100 has proven resilient to decisive reform. This article employs the ACF to explain this ongoing contestation and deadlock. It argues that both the highly contested nature of the health system and policy stasis are the result of the power dynamics between three identifiable advocacy coalitions. The analysis of the legislative proposals submitted to Congress of the Republic of Colombia between 1993 and 2014 reveals how the dominant coalition exploited mechanisms of the law making process to impede new legislation being successfully passed by Congress. For the ACF, these mechanisms are Relatively Stable Parameters (RSPs) that constitute long-term constraints and opportunities for subsystem actors. The article will show how RSPs in the Colombian legislative system shaped the health system reform process.

## **Keywords**

Advocacy Coalition Framework; Colombia; Health Systems Reform; Relatively Stable Parameters; Policy making.

## **Resumen**

Este artículo analiza el largo proceso de reforma del sistema de salud de Colombia, aplicando el marco de análisis de las coaliciones promotoras. Desde su origen en 1993, los principios organizativos y las estructuras que fundamentan el sistema de salud de Colombia han venido siendo altamente contestados. A pesar de esto, en estos más de 20 años de existencia, el sistema creado por la Ley 100 no ha llegado a ser sustituido o modificado en profundidad.

Este artículo aplica el marco de las coaliciones promotoras para explicar esta continua dinámica de disputa y parálisis. Se argumenta que tanto la permanente disputa sobre la naturaleza del sistema de salud como el bloqueo que impide consensuar reformas son el resultado de las dinámicas de poder entre 3 coaliciones promotoras. El análisis de las iniciativas de reforma del sistema de salud introducidas en el Congreso de la República de Colombia entre 1993 y 2014 revela cómo la coalición dominante aprovechó los mecanismos legislativos para impedir que propuestas de reforma tuvieran éxito. En el marco de las coaliciones promotoras, estos mecanismos son “parámetros relativamente estables” que constriñen a la par que suponen oportunidades para los actores del subsistema político. El artículo mostrará cómo estos parámetros del sistema legislativo Colombiano conformaron el proceso de reforma del sistema de salud.

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## **Introduction**

The Colombian health system is recognised internationally for the improvements it has brought about in key health outcomes (i.e. infant mortality) and in protecting the population against catastrophic impact of ill health. By 2014, 96.6% of the population had health insurance and out-of-pocket spending as total national expenditure on health had fallen to less than 15% (OECD, 2015). However, the health system faces important problems of equity, reflected, for example, in the huge variations in health outcomes between ethnic groups and between urban and rural areas. In 2014, for example, the maternal mortality ratio nationwide was 56.5 deaths per 100,000 live births, but the ratio for indigenous populations was 255.80 deaths, and in rural areas it was more than 233 deaths per 100,000 live births (MINSALUD 2016). In addition, the system suffers from endemic corruption resulting in a lack of continuity and low quality of care services. The waiting times for a specialist appointment rose from 10.4 days in 2003 to 19.2 in 2013 (OECD, 2015:76 – 77; Gaviria, 2015; Bardey 2017).

Since its creation in 1993, the Colombian health system has been highly controversial and there have been multiple attempts to reform it over time. None of these attempts have, however, resulted in fundamental changes to the basic model of health services provision (Restrepo, 2007). Nor have they been able to resolve the political contestation in the health sectors and achieve consensus between the main policy actors on the basic model of the health system. The current system remains organised in line with the principles set down in Law 100/1993, which brought the system into effect. In 2015, the latest step in this seemingly constant process of reform saw the passage of Statutory Law 1751, which, as with past reforms, addressed some immediate concerns with the

system but did not alter the core principles or the basic rights and responsibilities of patients within the health system.

In analysing the 20-year long process this article does not advocate major reform of the health system in Colombia; nor does it support the implementation for any particular health system model. The intractability of the policy debates around the Colombian health system presents an interesting case study for policy analysts. Why has the Colombian health system remained so highly contested and so resilient to decisive reform? We aim to tackle these questions through the applications of the Advocacy Coalition Framework (ACF) to the Colombian health systems debates. The ACF provides a conceptual lens through which to identify key policy actors, the coalitions which emerge amongst them, and the interactions between competing advocacy coalitions. The dynamics of these relationships – both within and between different advocacy coalitions – are used to explain policy stasis and policy change in the context of the institutional structures in which the policy subsystem is embedded (Sabatier, 1987; Sabatier & Jenkins-Smith 1999; Sabatier & Weible, 2007; Jenkins-Smith, Nohrstedt, Weible & Sabatier, 2014).

The Colombian health system reforms can be understood by analysing the power relations between three different coalitions of actors identified within the health subsystem and the ways in which their interactions are shaped by Colombia's complex law-making process. Since the inception of the current health system, health policy in Colombia has been shaped by a dominant coalition of actors comprising the main health insurance companies and private healthcare providers. Two challenger coalitions -

representing the medical establishment on the one hand and social movements, left-wing parliamentarians and public hospitals on the other – emerged but have not been powerful enough to undermine the hegemony of the dominant coalition and to bring about fundamental reforms. At the same time, other competing advocacy coalitions have failed to emerge as key actors have been unable to forge agreements or even basic consensus on key policy objectives.

From a comparative perspective, the ACF has been underutilised to understand the dynamics of policy making in Latin America. In recent decades, the ACF literature has expanded significantly (Sabatier & Jenkins-Smith, 1993; Sabatier, 1998; Sabatier & Jenkins-Smith, 1999; Sabatier & Weible, 2007; Weible, Sabatier & McQueen, 2009; Weible, Sabatier, Jenkins-Smith, Nohrstedt, Henry & deLeon, 2011; Jenkins-Smith et al., 2014) and a key area of expansion has been the application of the ACF to new geographical contexts (Sabatier & Weible, 2007, p.190; Weible, Sabatier & McQueen, 2009). However, as a recent review of ACF applications outside of Western Europe and North America between 1999 and 2013 shows, only 2 of the 27 studies have applied the framework to Latin American countries (Chile and Brazil) – far behind the 18 applications to Asian countries and the 6 to African countries (Henry, Ingold, Nohrstedt & Weible, 2014; Jenkins-Smith et al., 2014).

Furthermore, health policy has recently emerged as an area of interest amongst ACF scholars. Yet of outside of Western Europe and North America, only 3 out of 27 studies identified related to health issues (two on tobacco control, the other on water quality) and none focussed on health systems reforms (Henry et al., 2014). As far as we are

aware, there are no ACF applications to the analysis of health systems reforms in countries outside Western Europe and North America. The present article is a first attempt to fill this gap in the current literature, and to highlight the potential utility of the ACF in understanding the dynamics of health policy making in Colombia and Latin America.

Finally, the paper aims to contribute to the further development of a key element of the ACF's conceptual architecture. 'Relatively stable parameters' (RSPs) are the structures that embed a policy subsystem and influence interactions and power dynamics between advocacy coalitions. Despite their role in the policy process, RSPs have received relatively little attention from ACF scholars (Weible, Sabatier & McQueen, 2009, p.130; Montefrio, 2014), and their role in the development of policy has been under theorised. Following Montefrio (2014), this article seeks to highlight the significance of RSPs in explaining policy stasis and policy change, showing how coalitions strategically use basic constitutional structures and mechanisms of the state to shape the policy process. In the case of the Colombian health system, two aspects of the legislative process were vital to explaining the failure of successive health reform proposals: the possibility of introducing and appending additional draft laws on related topics to an existing draft law at any time in the legislative process; and the requirements that all draft laws be approved within a specific timeframe. The ability to expand and complicate legislative proposals in the context of strict legislative time limits was used strategically by the dominant coalition to delay and impede any decisive reform.

### **The Advocacy Coalition Framework**

According to the ACF, policy actors – defined broadly to include legislators, civil servants, researchers, journalists, interest groups, stakeholders and advocates – ‘coalesce’ into advocacy coalitions centred on a shared set of basic beliefs (Montefrio, 2014). The coalition’s belief system includes the perceptions of policy problems and their causes as well as policy goals designed to address these problems, and perceptions about the ease with which policy can be changed. In the conceptual vocabulary of the ACF, advocacy coalitions are defined in terms of *deep core beliefs*, *policy core beliefs* and *secondary beliefs*. At the broadest level, deep core beliefs ‘involve very general normative and ontological assumptions about human nature, the relative priority of fundamental values such as liberty and equality, the relative priority of the welfare of different groups, the proper role of government vs. markets in general and about who should participate in governmental decision-making’ (Sabatier & Weible, 2007, p.194). At a narrower level of abstraction, policy core beliefs ‘are applications of deep core beliefs that span an entire policy subsystem’ and cover key questions related to policy debates such as ‘the priority of different policy-related values, whose welfare counts, the relative authority of governments and markets, the proper roles of the general public, elected officials, civil servants, experts and the relative seriousness and causes of policy problems in the subsystem as a whole’ (Sabatier & Weible, 2007, pp.194-5). Finally, at the lowest level of abstraction, secondary beliefs ‘address, for example, detailed rules and budgetary applications within a specific program, the seriousness and causes of problems in a specific locale, public participation guidelines within a specific statute, etc.’ (Sabatier & Weible, 2007, p.196) Whilst deep core and policy core beliefs are very difficult to change, secondary beliefs ‘require fewer agreements among subsystem actors’ and thus, in principle, are less difficult to modify (Sabatier & Weible,



2007, p.196).

Typically, between two and five advocacy coalitions compete within a given policy subsystem, and seek to shape decision-making in this area in line with their policy preferences. ACF scholars differentiate between *dominant* and *non-dominant* coalitions; and between those who are 'insiders' and 'outsiders' within the policy-making process (Gupta, 2014). 'Insider' groups enjoy privileged access to the executive; employ established, mainstream lobbying and policy influencing strategies; and their views tend to be widely considered by decision makers. Meanwhile, outsider groups are largely excluded from the corridors of power, leaving them to adopt less conventional strategies to try to influence decision including highlighting issues through mass media, raising petitions and organising demonstrations (Page, 1999; Gupta, 2014). In this article, we identify three coalitions that populate the health policy subsystem in Colombia. We name these the 'dominant', 'challenging insider' and 'opposing outsider' coalitions.

Policy change requires changes in the belief systems of key policy actors, which are, in turn, sparked by disruptive events in the policy equilibrium within the policy subsystem. These may include external or internal perturbations to the policy subsystem (e.g. leading to a redistribution of resources of subsystem actors), negotiated agreements among actors or policy-oriented learning (e.g. due to the emergence of new evidence on a certain topic).

According to the ACF, two sets of factors external to the policy subsystem are critical in facilitating or constraining policy change. One set of external variables – which the ACF has largely considered as ‘a critical prerequisite to major policy change’ (Sabatier and Jenkins-Smith, 1999, p.120) – includes changes in the prevailing socio-economic conditions, in public opinion or in the governing coalitions, as well as shocks or events occurring in other, related subsystems. These changes provide short-term constraints and resources which subsystem actors may exploit. Policy subsystem dynamics between advocacy coalitions are conditioned by a second set of external variables, which are resistant to change and constitute long-term constraints and opportunities for subsystem actors. These are ‘the basic social, cultural, economic, physical and institutional structures that embed a policy subsystem’ which the ACF terms RSPs (Jenkins-Smith et al., 2014, p.193). Thus, belief conflicts and the evolution of coalitions over health policy are affected by the RSPs which prevail in the specific context in which policy debates occur.

Examples of RSPs identified within the ACF literature include the basic attributes of the problem area, the basic distribution of natural resources in the country, the fundamental socio-cultural values and social structures and the basic constitutional structure of the state (e.g. the electoral system, party system and the legislative process) (Montefrio, 2014). Socio-cultural values include the political culture of the country. In the case of Colombia, there is a deeply embedded culture of patron-client relationships within all levels of government and widespread political corruption (Botero, Hoskin & Pachón, 2010). This emerged in the context of the ongoing conflict between the Government and various armed groups in different regions of the country,

and Colombia's central position within the global trade in illegal narcotics (Dargent, 2015), although efforts have been made to address both of these situations. According to recent figures, from 2000 to 2013, Colombia succeeded in reducing coca cultivation from 160,000 hectares to 48,000 hectares (Mejía, 2016) and a peace settlement with the guerrilla forces reaching an advanced stage at the time of writing. Still, both dynamics remain vitally important contextual variables with far reaching social and political consequences which it is vital to consider when analysing policy dates. Constitutional factors, and their impacts on the health systems reform, will be the key focus of the current article.

### **The institutional configuration of the Colombian state and the law making process**

The 1991 Constitution established Colombia as a presidential democracy, where the President of the Republic is elected every four years to become the Head of State, the Head of Government and the highest administrative authority. The legislative branch is formed of a bicameral Congress – with a Senate (Senado), and a Chamber of Representatives (Cámara de Representantes) - also elected every four years.

The institutional reforms of the 1991 Constitution replaced the two-party system of the 1990s by a highly fragmented multi-party system, characterised by high levels of electoral volatility (whereby many new parties are created but often cease to exist after only one or two elections cycles) (Botero, Losada & Wills, 2011). In 2003, a reform of the electoral system (which introduced the D'Hont system for allocating seats and open lists

of electoral candidates) reduced party fragmentation to a certain extent, going from 42 parties with Congressional representation in 2002 to just 10 parties in 2006 elections.

Political parties in Colombia are weakly structured, with parties serving as electoral vehicles, which are used by candidates to promote their own personal candidacies and to mobilize electorates (Milanese, 2011; Jones, 2010). As Pachón and Hoskin (2011, p 20) comment:

even though political parties play a more important role in campaigns after the 2003 electoral reforms, the outcome of those races depends primarily upon the efforts and financing of individual candidates, not their partisan affiliations.

Consequently, members of the same party may have different (or even conflicting) ideological beliefs. As Pachón and Johnson (2016, p.76) note:

Colombia's history of candidate-centred electoral rules has undermined attempts to build parties focused on national goals, leading instead to ideologically heterogeneous parties and legislators prioritizing distributive pork-barrel projects.

Within Congress, there are very low levels of party discipline, and party leaders have few controls over parliamentarians to secure their support for (or opposition to) specific policy initiatives.

Due to this, Colombia has been characterised as having a highly fragmented, decentralized legislature (Pachón and Johnson, 2016). In turn, the President of the

Republic enjoys key powers (including urgency message; legislative decrees; capacity to veto Congress projects; freedom to initiate laws in key policy areas) which grants him strong legislator role, although subject to compromises with parliamentarians. The relatively superior position of the President (and by extension, the executive) versus the legislative branch should not be understood in a hegemonic logic but rather limited to negotiating with parliamentarians (Milanese, 2011).

Within Congress, the legislative process is governed by Law 5 of 1992 that regulates the functioning of both chambers. Parliamentary sessions last from 20 July until 20 June of the following year. Draft laws can be introduced by the Government (i.e. Ministers), Members of Parliament (MPs) or members of the public, in either the Chamber of Representatives or the Senate. At any point in the legislative process, any draft law on the same topic as an already registered draft law can be introduced into Congress, and thus the new proposal becomes 'accumulated' to the existing draft law for joint parliamentary discussion. Very often though the addition of additional proposals results in significant complications and delays.

The process starts either in the Senate or in the Chamber of Representatives, depending on where the Bill is first registered. This first debate occurs in the Permanent Commission of the respective chamber and a vote is taken on whether to approve the draft. In contrast to most legislatures in Latin America, in which parliamentary commissions have only advisory powers, 'committees in Colombia constitute the first stage of bill approval and can prevent bills from ever getting to the floor...While most other legislatures and Parliaments around the world reserve the right to discharge

legislation from committees, in Colombia, the decision of the Committee is final' (Pachón and Johnson, 2016, p.73).

If it is approved, the draft moves to the plenary of the chamber in question. Once the plenary has approved it, the draft is sent to the other chamber for approval by the relevant commission and the plenary. If there are differences between the approved texts in each chamber, a consolidated draft is produced by an appointed committee consisting members of each chamber. The final stage of the passage of the draft into law is approval by the President of the Republic. In the case of statutory laws (and those issued under any of the extraordinary procedures), the Constitutional Court must review the draft law before the President's signature.

According to article 190 of Law 5 of 1992, which governs the functioning of the Parliament, only draft ordinary laws that have managed to be approved in the first debate in any of the Chambers may to continue their passage in the following legislative session. However, no draft law can remain under discussion for more than two legislatures. In the case of statutory laws, article 208 of Law 5 of 1992 states that they have to be enacted within a single legislature. As we will show in the analysis below, with various health reform attempts the combined effect of the requirements for draft laws to be approved within tight time limits, along with the possibility to accumulate additional draft laws to a previously registered proposals, creates a mechanism through which policy actors can effectively stymie the progress of new legislation which they oppose.

Congress' operational regulations set out a series of extraordinary procedures which can be followed in specific situations. One of them is an 'urgency procedure' whereby the President of the Republic can request a higher priority be given to a specific legislative process, so that the passage of the Bill should last no more than 30 days in each chamber. The procedure allows for joint deliberation by the Commissions of the Senate and the Chamber of Representatives with a single vote to approve the draft law. The draft law is then debated jointly by the two chambers on plenary sessions, but with each chamber voting on the Bill separately.

### **Methodology**

ACF scholars have used multiple methods of data collection, including interviews, content analysis, questionnaires, observational studies or combinations of these (Weible, Sabatier & McQueen, 2009; Leifeld, 2013). This article draws on data generated from semi-structured interviews with policy actors engaged in health policy and health systems reform debates in Colombia. Potential respondents were identified through purposive sampling on the basis of: (i) the previous experience of one of the researchers working in the country; (ii) the identification of key institutional actors from scholarly and 'grey' literature on contemporary Colombian health policy debates; (iii) two scoping interviews with Colombian informants conducted in December 2013; and (iv) 'snowballing', whereby existing contacts were asked to suggest other potential interviewees for use to contact (Bryman, 2015). We conducted 26 interviews with key health policy actors (including policy advisers and civil servants at the national level, interest groups representatives, academics, health policy experts and commentators) in Colombia in February 2014. At this point we considered that reached saturation, with

additional interviews not adding to the information that had already been collected (O'Reilly & Parker, 2013).

Prior to conducting interviews, we selected four variables for differentiating deep core beliefs related to the health system: a) the extent of private vs. public provision; b) the extent of private versus public financing of health care; c) the basis of eligibility for healthcare (i.e. who is entitled to receive care); d) and the role (and autonomy) of the medical profession. By combining these key variables, we cover key issues of financing, service delivery and regulatory structures which different models of health system (i.e. tax funded national health services as in the UK and private insurance models in countries such as Germany) (Wendt, Frisina and Rothgang, 2009).

Through the interviews, we sought to identify coalition membership and their belief systems. Interviews were conducted by both authors in tandem, which allowed for detailed research notes to be taken whilst the interviews were conducted. These were consolidated and cross checked for accuracy and understanding between authors immediately after each interview. Notes were used to refine and develop interview guide and introduce additional and improved questions in subsequent interviews. In almost all cases (N=22), interviews were recorded, transcribed and thematic coding of the transcripts was completed using Nvivo qualitative analysis software. Where respondents declined to be recorded we relied exclusively on the research notes. Quotes from the interviews in Spanish have been translated by the authors and are



given in English.<sup>1</sup>

In addition to the interviews, we analysed the key legislative proposals aimed at reforming the Colombian health system submitted to Congress between 1993 and 2014.<sup>2</sup> The identification of legislative proposals started from a review on the existing scholarly literature on Colombian health policy and applied the ‘snowballing’ technique, whereby reviewed draft laws included references to previous projects which were then retrieved and reviewed. Finally, different publicly available sources, such as the official bulletin of the Congress of the Republic of Colombia<sup>3</sup> and the online archive *Congreso Visible*<sup>4</sup> were used to systematically identify legislative initiatives. The comprehensive analysis of draft laws submitted to Parliament over a 20 year period allowed for the cross-checking of dates, the identification of the legislators who submitted them (and the advocacy coalitions which supported them) and the follow up of the progress of draft laws through the legislative process. This revealed the way political actors made strategic use of the law making arrangements in Colombia for shaping the health system

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<sup>1</sup> The Spanish names and acronyms of key Colombian organisations (i.e. Gran Junta Médica, GJM) are used through the paper. Translation into English is provided at their point of first usage.

<sup>2</sup> Colombia has a hierarchical structure of laws, with the Constitution at the top of this hierarchy, followed by laws produced by the bicameral Congress (made up of the Chamber of Representatives and the Senate), and then decrees and other regulations produced by the executive branch. Congress produces three different types of legal instruments: Statutory laws (Leyes Estatutarias), Organic Laws (Leyes Orgánicas) and Ordinary Laws (Leyes Ordinarias). Statutory Laws regulate fundamental rights and obligations for people, justice, citizen participation, exceptional state situations, which are explicitly stated in the Constitution. After their passage through Congress, Statutory Laws are reviewed by the Constitutional Court before the President signs them. Organic Laws are used to establish the regulations of the Congress, of the state budgeting process and the devolved powers of local authorities. The approval, modification or abolishing of Statutory and Organic Laws require the absolute majority of Chamber of Representatives to be approved and has to happen within the same legislative period. For an introduction, see Vanegas (2012).

<sup>3</sup> Available on the public domain at the <http://www.imprenta.gov.co/gacetap/gaceta.portals>

<sup>4</sup> Available on the public domain at <http://www.congresovisible.org>

reform process throughout this period.

### **Identifying advocacy coalitions**

Before 1993, Colombia health system had a single public insurer. Law 100 passed that year introduced mandatory health insurance under regulated competition for both insurance funds and healthcare providers through a managed care model (Glassman, Escobar, Giuffrida & Giedion, 2009; Bernal, Forero & Forde, 2012). Both public and private health insurance funds (the Empresas Promotoras de Salud, EPS) perform a delegated function. They manage the affiliation and registration of people to the health insurance regime, organise and ensure the provision of the basket of basic services called the Compulsory Health Plan (Plan Obligatorio de Salud, POS). The EPS then enter into contractual arrangements with multiple private sector health care providers (the Instituciones Prestadoras de Servicios, IPS) and with public hospitals, reclassified as Social State Enterprises, to provide health services for their members.

Since the passage of the Law 100, various attempts to reform the health system (and to resist such reforms) have been promoted by the different advocacy coalitions. Fundamental disagreements have endured on the four key issues: the financing of the system (i.e. insurance versus taxation based models); the involvement of private sector; the autonomy of the medical profession; and whether limits can or should be placed to the right to healthcare. Policy actors have aligned around distinct sets of deep core beliefs on these issues, eventually forming three different advocacy coalitions in the health policy subsystem.

Authors have proposed different periodizations and with a variable number of stages, depending on the span of time studied<sup>5</sup>. We have chosen a two-stage periodization which derives from the aim of our analysis, which is the study of the evolution and interactions of health advocacy coalitions:

1. **1993-2010:** This period began with the passage of Law 100 during the administration of President César Gaviria (1990-1994) and saw the partial implementation of the Law 100 during the subsequent presidencies of Ernesto Samper (1994-1998) and Andrés Pastrana (1998-2002). During this time, a “dominant” coalition of government technocrats, congressmen, insurance companies, the financial sector and the private health providers (including the pharmaceutical companies) emerged and was able to shape the health policy agenda. Then, between 2002 and 2010, under the two administrations of President Uribe, a set of actors began to emerge but were not at this juncture effectively coordinated as a coalition of actors. This period saw significant attempts to reform the healthy system culminating in the declaration of a state of emergency in 2009.

**2010 - 2016:** the second phase began under the current Presidency of Juan Manuel Santos in 2010 and this article analyses the period up to 2016. A gradual coalescing of actors into distinct advocacy coalitions, increasingly coordinated and mobilised around shared beliefs and policy solutions, began to challenge those of the “dominant coalition”. The emergence of “challenging” coalitions occurred in parallel with the weakening of the “dominant coalition” and the gradually weakening relationships between this coalition and successive Ministers of Health. However, as the recent passage of Statutory Law 1751 – which confirmed the principles and values of the

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<sup>5</sup> For example, only for the period of Law 100 formulation and implementation (between 1991 and 2000), Manuel Vega-Vargas and colleagues differentiate 4 stages, which do not coincide with Jaramillo’s 3 stages of the same period. See Vega-Vargas, Eslava-Castañeda, Arrubla-Sánchez & Hernández-Álvarez, 2012; Jaramillo, 1998).

existing health system, whilst clarifying the rights and responsibilities of patients – demonstrated, the two challenger coalitions of actors have not been powerful enough to override the hegemony of the dominant coalition and cross-coalition agreements have not been achieved.

### ***1993-2010***

Law 100 was passed during the Gaviria administration, in the context of a wider programme of the state reforms, which included the enactment of a new constitution (Vega-Vargas, Eslava-Castañeda, Arrubla-Sánchez & Hernández-Álvarez, 2012; González-Rosetti & Bossert, 2000; Jaramillo, 1998). These political reforms strengthened the power of Congress, so that it was able to impose policy initiatives on the Executive, including health reforms (González-Rosetti & Bossert, 2000, p.24). ‘The health reform was not part of [President Gaviria’s] initial policy agenda, which focused on the social security reform. Instead, it was the concession the Executive had to make to Congress in order to have the pension reform approved’ (González-Rosetti & Bossert, 2000, p.26). Minister of Health Juan Luis Londoño took up the task of reforming the health system, following the advice of a group of experts from Harvard School of Public Health.

The constitutional changes introduced in this period provided the government with an immediate opportunity to undertake a fundamental reorganisation of the key actors of the health policy subsystem. Law 100 passed through Congress very quickly with the entire process of formulation and approval taking just three years to complete (Hernández, 2005; González-Rosetti & Bossert, 2000). A close relationship was forged between the economic change teams at the Ministry of Finance, the National Planning

Department (Departamento Nacional de Planeación, DNP) and the Ministry of Health, facilitating the formation of a coalition of government technocrats, Congressmen, insurance companies (including the financial sector) and the private health providers (including the pharmaceutical companies). This became the 'dominant' coalition in the health sector and, within it, the health insurance funds (EPS) gradually assumed a prominent role, coordinated by ACEMI (the association of private insurers). According to Manuel Vega-Vargas and colleagues, private insurers 'had been present, in one way or another in previous debates', but it was in the early months of 1993 when they voiced their interests more visibly through ACEMI (Vega-Vargas et al., 2012, p.65). The deep core beliefs of the coalition members focussed on the need to ensure health system efficiency through market competition with private sector participation (i.e. a competitive market of private and public providers); a fundamentally private insurance-based financing system with public funds for citizens not able to contribute and for public health interventions; and, as a consequence of the financing mechanism, a two-tier entitlement system (a contributory system for the majority of the population and a subsidiary system for those unable to afford contributory schemes). The autonomy of the medical profession did not constitute a deep core belief for this coalition. Table 1 below expands on the deep core, policy core and secondary beliefs of the main advocacy coalitions.

[Table 1 here]

Other key policy actors, including the medical establishment, were excluded from the processes leading to the enactment of Law 100 and were initially unaware of the extent of the impact that the reforms would have (Interview num. 8). The Ministry of Health change team 'decided to give priority to the development of the new actors that were

to operate under the new system, instead of concentrating on the direct transformation of the old existing ones, which presented great political obstacles' (González-Rosetti & Bossert, 2000, p.28). Such a fundamental re-balancing of the actors within the health policy subsystem was made possible by the changes implemented to the basic constitutional structure of the Colombian state with the adoption of the 1991 constitution and by the focussed and highly skilled strategy pursued by Ministry of Health. As the new 'dominant coalition' of policy actors emerged, no other coalition of actors, either from the medical establishment or the political left (Vega-Vargas et al., 2012), were able to articulate an effective response to, or challenge its power. This was due to significant internal divisions which existed in these communities (Hernández, 2005).

The exclusion of key policy actors outside the dominant coalition from the process of designing, formulating and passing Law 100 resulted in significant problems at the implementation stage. It precluded the formation of basic agreements amongst key health policy stakeholders on the fundamental assumptions underpinning the health system. The challenges this posed for the implantation of such a fundamental reform were further compounded by changes in the political landscape. In August 1994, only seven months after Law 100 was approved, Ernesto Samper was elected President, replacing Gaviria. Samper's first Health Minister, Alonso Gómez (1994-1995), undermined the implementation of Law 100 by impeding the participation of the private sector in health and legislated instead to strengthen the role of the public territorial entities (through the decree 2491 of 1994) (Vega-Vargas et al., 2012). Since the new government 'was not completely aligned with the principles of the reform' (González-

Rosetti & Bossert, 2000, p.6), the adoption of secondary legislation necessary for the implementation of the new health system was delayed, as reflected in the fact that the first group of private insurance companies in the contributive regime were authorised by Health Minister Augusto Galán Sarmiento, who replaced Alonso Gómez in July 1995. As a result, the reform process lost vital momentum.

1994 also marked the start of an economic downturn in Colombia that culminated in the recession of 1998-1999. This occurred in the context of an intensification of the internal armed conflict, 'which displaced about 580,000 people between 1998 and 2001'(Glassman et al., 2009, p.6). As a consequence of these factors, the health reforms set out in Law 100 had only had been only partially implemented by 2001. Although it had improved substantially (from 20% to 53% of the population) insurance coverage remained far from universal (González-Rosetti & Bossert, 2000) and the health system was starting to face a 'severe and generalized financial crisis' (Glassman et al., 2009, p.7). In the area of health, the 1998-1999 economic recession revealed the crisis facing the public hospitals, which following the implementation of Law 100 were no longer in direct receipt receiving public funds from the government, but instead had to contract their services with the EPS. However, the debts and payment delays by the latter and the breach of government responsibility for funding the care provided to the non-insured population, led many hospitals into serious financial difficulties, and eventually to closure (Uribe, 2009).

The Presidential election of May 2002 brought President Alvaro Uribe to office. Uribe subsequently re-appointed Juan Luis Londoño, the Minister responsible for the passage of Law 100, as Minister of Health, tasking him with completing the implementation of the health system reforms began in 1993 (Glassman et al., 2009, p.7). However, the renewed momentum for reform was again lost with the sudden, tragic death of Minister Londoño in an air crash in February 2003. His successor, Diego Palacio, remained in office for seven years, but failed to implement the deep reforms that his predecessor had envisaged.

During Uribe's presidencies, the health policy subsystem continued to be dominated by the same coalition of actors, in the absence of competing coalitions able to form and coordinate effectively. At the same time, the financial unsustainability of the health system grew to a crisis point. This period saw two waves of draft laws submitted by Congressmen reflecting the views of health stakeholders. These were not measures aimed at improving the implementation of Law 100 but rather at challenging the whole basis of the Law 100 system and seeking more fundamental health system reforms. However, none of the proposed measures were eventually passed (Hernández, 2005).

The first wave of reforms originated in 2003 with draft law PL180/2003S and its accumulated projects, while a second wave of 11 draft laws were submitted to Congress in 2004, accumulated to PL52/2004S (Guzmán, 2006). Both waves of draft laws ran out of time during the Congressional session and thus were abandoned. As will be argued below, competing policy coalitions seeking changes to the health system needed to work within the institutional parameters that determined the policy process when seeking to influence the reforms.



The failure of these reforms was a source of significant anger amongst policy makers and commentators, with some describing these missed opportunities as a ‘frustration’, ‘failure’, ‘deception’, or even a ‘fraud’ (Guzmán, 2006). Following this intense period of activity, no further legislative initiatives were introduced into Congress for the next two years. Instead, the Ministry of Social Protection announced a change of strategy which consisted of introducing changes to the system through secondary legislation that would not require congressional approval (Guzmán, 2006). In 2007, Law 1122 was passed by Congress, which focused on strengthening system regulations, although the secondary legislation necessary to give force to the law were not subsequently brought forwards.<sup>6</sup> In the absence of more substantial reforms, the economic unsustainability of the health system was not addressed and financial deficits began to mount. Thus, ‘by the end of the decade, the health system was in deep crisis’ (Bernal et al., 2012, p.25). In terms of results though, as of 2008, the financial protection of the population had improved dramatically (85% of the population was insured) and access to and use of health care services had increased significantly, particularly for the poor (Escobar,

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<sup>6</sup> An important landmark in the process of health reform was the Constitutional Court (CC) sentence T-760 of 2008, which aimed to tackle the issue of *tutelas*, and points to the massive (and controversial) role of the Constitutional Court in policy making in Colombia. Tutelas are writs of protection of fundamental rights, by which any person that feels that his/her fundamental rights (i.e. to access health services, treatments or pharmaceuticals) are being threatened or violated can go to any judge in the country and request protection. However, the total number of tutelas has grown exponentially over the years, to the point that it has been identified as one of the key challenges to the sustainability of the health system. The T-760 sentence then aimed to give a structural approach to the functioning of tutelas and thus introduced a mechanism of ‘complex orders’ in an attempt to orientate the judgements of lower courts through an structured route rather than on a single case (*casuist*) basis. In aiming so, T-760 sentence implied an appeal to the government and the legislative to undertake a deep restructuring of the country’s health system. The analysis of the role of the judiciary versus other branches of the state is however beyond the scope of our article. For a broad overview of both the tutelas and the role of the CC, see Yamin & Parra-Vera (2009); Rodríguez-Garavito (2012).

Giedion, Giuffrida & Glassman, 2009). However, these apparently positive results were strongly challenged by critics, who denounced problems of equity, low quality of services, fragmentation, etc. (Hernández & Torres-Tovar, 2010; Yepes, 2010).

In 2009 President Uribe declared a 'state of economic, social or ecological emergency' under which it was possible for the government to produce a series of decrees with the specific aim of reforming particular aspects of the health system to ensure its viability. This provoked strong public opposition with health groups taking to the streets to demonstrate against the proposed reforms. In April 2010, the Constitutional Court declared the state of emergency unconstitutional and annulled the Emergency Decrees adopted under its auspices. The 2009 events had had great effects on the health policy subsystem. The political gridlock, the public demonstrations against the emergency decrees and their final annulment by the Constitutional Court led to a gradual re-balancing of power, which translated into the weakening of the dominant coalition and the setting up of two alternative coalitions.

### **2010-2016**

President Juan Manuel Santos was elected in August 2010 with a promise to undertake major health system reforms (Bernal et al., 2012, p.26). The principal challenge faced by the new government was the financial unsustainability of the health insurance system. A series of draft laws were introduced to Congress during the second half of 2010 by different parliamentarians representing the interests of the competing advocacy coalitions. A number of statutory draft laws to define 'the essential core of the right to health' were discussed in Parliament, reflecting again the various actors' positions, but

none were passed in the legislature and were eventually abandoned. For the dominant coalition, the solution to the crisis was to introduce more effective regulations of the existing the institutional arrangements established by Law 100. As we will see below, however, the internal coherence of this coalition would gradually weaken but, at least on this point, the consensus view was that a strengthened regulatory framework (including greater controls on service providers and insurers, better information systems, more stewardship role for the Ministry of Health) would create the correct incentives for the health market to operate effectively and thus avoid the need for citizens to resort to judicial mechanisms in order to gain access to healthcare.

In this period, the medical establishment stepped up their active advocacy for health system reform and a 'challenging insider' coalition gradually began to emerge around the National Academy of Medicine (Academia Nacional de Medicina). Other members of this coalition included the Colombian Association of Scientific Societies (Asociación Colombiana de Sociedades Científicas), the Colombian Medical Federation (Federación Médica Colombiana), the Colombian Medical College (Colegio Médico Colombiano) and the Medical Trade Union Association (ASMEDAS). In addition, the coalition consisted of journalists (especially those from the newspaper El Tiempo), academics and politicians. In 2012, the coordination of the 'challenging insider' coalition was greatly enhanced by the formation of the Great Medical Board (Gran Junta Médica, GJM), which emerged as one of the most powerful lobby groups in the country.

For this coalition, the unsustainability of the existing system was the key issue facing the Colombia health system. This, in turn, they argued, was due to the uncontrolled profit-

seeking behaviour of health insurers (EPS). In their view, those most able to make correct and effective clinical decisions – the medical profession – had lost their autonomy, and their clinical decision making role had been usurped by the EPS. This constituted a deep core belief at the heart of the ‘challenging insider’ coalition which manifested itself in their advocacy of a self-regulated medical model within a publicly insured system. In this model, intermediation by insurers would be abolished and the EPS would be relegated to the status of ‘administrators’ but would exercise little if any control over service provision. Thus, it believed in a publicly funded system with mixed public and private service provision. Of great importance for the ‘challenging insider’ coalition was doctors’ autonomy to take clinical decisions. However, the issue of eligibility (i.e. who is entitled to receive health care) was not a key concern for the coalition.

At the same time, an ‘opposing outsider’ coalition started to emerge. This occurred in parallel to the increased mobilisation of a range of social movements, leading to street protests throughout the Santos presidency against the free-trade agreements and the mining and energy policies, and their impact on rural, education, and health sectors (Cruz, 2014a; 2014b). The ‘opposing outsider’ coalition was a wide alliance of social movements, academics from Universidad Nacional (National University) and other public universities, left-wing parliamentarians and medical organizations such as the Association of Medical Interns and Residents (Asociación Nacional de Internos y Residentes, *ANIR*) and the Association of Public Hospitals (Asociación Colombiana de Empresas Sociales del Estado y Hospitales, *ACESI*), now coordinated through the National Assembly for the Right to Health (Mesa Nacional por el Derecho a la Salud).

Despite being very active in proposing reform policies to Parliament, they also used mass media (i.e. newspapers such as *El Espectador*) and resorted street demonstrations coordinated by the National Assembly for the Right to Health to counter their outsider status regarding access to governmental decision-making.

For this group of agents, the existing health system under Law 100 was profoundly inequitable and unfair. Despite governmental claims of universal health coverage, they argued, such coverage was nominal and largely ineffective. Much of the blame for the current state of affairs was placed on health insurers, leading them to argue that that the EPS should be abolished in order to return to the pre-1993 model of state-based provision.

The most fundamental deep core belief centred on access to healthcare grounded in a human rights framing of the debate. Healthcare, they contended, is a fundamental right that people are guaranteed as a consequence of citizenship, not economic or labour market status, and hence not as a result of their ability to contribute to health insurance schemes. People have the right to the highest level of health care possible, without discrimination on any grounds. Thus, health care should be both guaranteed and provided by the state through public funding and mainly public provision of services, with some role permitted for not-for-profit providers. The role of insurers and all forms of intermediation, meanwhile, should be eliminated (Hernández, 2005; Hernández & Torres-Tovar, 2010). The role and autonomy of the medical profession did not constitute a deep core belief for this 'opposing outsider' coalition.

The emergence of these two competitor coalitions coincided with the weakening of the dominant coalition as the government, and in particular the Ministry of Health, felt compelled to tackle the financial unsustainability of the system. The weakening of the dominant coalition was exacerbated by the emerging controversies surrounding the country's main insurance providers, including the biggest EPS, SaludCoop. In less than two decades, SaludCoop grew to become one of the ten biggest businesses in Colombia. However, questionable investments led to serious financial problems that moved the government to intervene in May 2011 and remove the management team. See Quevedo (2012).

In this context, the government prioritised developing health systems reforms through ordinary legislation, and thus promoted draft law PL01/2010S which was jointly debated with a series of other draft laws accumulated to it (e.g. PL 143/2010S, PL 126/2010C). The determination of the government to pass this legislation is reflected in the use of a 'message of urgency', which is a presidential prerogative designed explicitly to speed up the legislative process (Hernández & Torres-Tovar, 2010). This process resulted in the passage of Law 1438 in January 2011. Law 1438 aimed to unify the contributory and the subsidized regimes, to strengthen primary care and to promote of service provider networks, but it did not change the fundamental contours of the existing health system. It was strongly opposed by the medical organizations who criticized the government for failing to take into account the opinions and contributions of the health care professionals in the formulation of the law and for failing to tackle the underlying problems of the health system (Muñoz, 2011). It was also opposed by other actors within the opposing coalition on the basis that Law 1438 in their view simply

“strengthened the mistakes of Law 100” (Guzmán, 2011). As with the initial passage of Law 100, the non-inclusive legislative process compromised the government’s ability to deliver secondary legislation through which to implement the measures set out in Law 1438 (Interview num. 10).

A new window of opportunity for policy change opened up in the summer of 2012, with the introduction before Congress of four draft statutory laws and one ordinary draft law, reflecting the views of different advocacy coalitions. Thus, when Alejandro Gaviria replaced Beatriz Londoño as Minister of Health, in September 2012, there already were a number of reform proposals on the table from different coalitions.

The ‘challenging insider’ coalition began to enjoy increased access to key policy makers at both the Ministry of Health and the Presidency. In December 2012, the GJM, the key coordination mechanism of the coalition, presented of a 14-point draft statutory draft law to President Santos, who in turn made a personal commitment to take the proposal forward as the basis of a draft statutory law. However, the new ministerial team was determined to retake the political initiative on the reform of the health system and, as statutory laws were subject to tougher legislative requirements, they decided to introduce reforms through the means of ordinary laws. Thus, the government proceeded to develop both a Statutory Law and an Ordinary Law in parallel. The aim of the Statutory Law was to establish the precise content of the right to health and the responsibility of the state for health (Hernández, 2013). The Ordinary Law, meanwhile, would define the structure of the health system that would be tasked with guaranteeing the right to health as defined by the Statutory Law.

On 19 March 2013, President Santos registered the draft Statutory Law at the First Commissions of the Senate and Chamber of Representatives. On the same day, Minister Gaviria registered the draft Ordinary Law 10/12 at the Seventh Commissions of the Senate and Chamber. As Jaramillo (2013) noted, the registration of the two draft laws in different chambers was due to the specific nature and scope of each draft law. As Statutory Laws regulate fundamental rights and obligations explicitly stated in the Constitution, they are dealt with by the First Commissions of the Senate and the Chamber of Representatives. The First Commissions are considered the politically most important of all parliamentary Commissions and are thus the focus of interest of the most powerful and influential legislators. On the other hand, Ordinary health laws are registered at the Seventh Commissions, since they deal with welfare policies including social security, health care, housing, women and family matters, etc. Nevertheless, despite having been registered and debated in different parliamentary Commissions due to their specific nature and scope, both draft laws were clearly part of a same legislative package.

The 'opposing outsider' coalition mobilised in opposition to both draft laws to put pressure on parliamentarians with heavy lobbying, street demonstrations, and social media campaigns. Throughout the legislative process, right up to the final approval of the draft law by the parliament on 19 June 2013, there were extensive debates about the proposals between policy makers and stakeholders which fundamentally transformed the original 14-point proposal of the 'challenging insider' coalition (and brought about its gradual opposition to the draft that they had originally promoted).



The draft Statutory Law was sent to the Constitutional Court for revision, and almost one year later, the Court declared it constitutional. The Statutory Law 1751 was finally enacted on 16 February 2015. For the Opposing Outsider coalition though, the law did little more than confirm the principles and values of the health system in Colombia and the rights and responsibilities of patients. As such, its passage has not brought about a fundamental change in the design and functioning of the health system. As one respondent from the Opposing Outsider Coalition commented: “The statutory law doesn’t get to the heart of the problem”; [Interview 10].

Minister Gaviria’s draft Ordinary Law PL 210/2013S (and its twin project at Congress PL147/2013C) went through a number of public consultations throughout the country in April and May 2013, allowing stakeholders to feed into debates on the content of the law. According to critics from across the spectrum of actor stakeholder groups involved in the policy process, and particularly those aligned with the Opposing Outsider Coalitions, the law proposed only cosmetic changes to the functioning of the health system, since the insurers (EPS) would continue to be extremely powerful and able to avoid effective accountability and control mechanisms. However, for the ministerial team, as proponents of the law, the bill was proposing radical changes to the health system, including the definition of a new status of EPS without much managerial capacity over financial resources and the setting up of a single pool fund (Salud Mía).

The legislative process in the Seventh Commission of the Senate progressed successfully and so the Senate Plenary approved the text of the law on 16 October 2013, at a time when there was a strong mobilisation of social groups and protests against the law led

by the 'opposing outsider' coalition. The draft law PL 210/2013S then passed to the Chamber of Representatives for approval under the code PL 147/2013C. However, the draft was rejected in both the first debate in the Chamber of Representatives and in the second debate in the Senate and so the Bill was archived. Having failed to be approved by either the VII Permanent Constitutional Commission or the Plenary of the Chamber of Representatives, the draft law was abandoned.

The re-election of President Santos in May 2014, and the retention of Alejandro Gaviria as Minister of Health, allowed the government to introduce a new Ordinary Law in a new legislature period. With modifications, some of the financial mechanisms proposed in PL 147/2013C were incorporated into the new draft law PL 24/2014S, which was introduced before the Senate in July 2014. The resulting Law 1797 (enacted on 13 July 2016) introduced a number of financial and managerial tools, with the declared purpose of tackling service providers' debts, easing the flow of funds through the health system and improving the quality of services. The 28 articles contained in the Law 1797 were all that remained from the 92 proposed in the initial PL 210/2013S (and its twin project at Congress PL147/2013C).

### **RSPs in the Colombian health Systems Reform**

The above review of the Colombian health reform processes between 1993 and 2014 reveals how the competing advocacy coalitions had to operate within the institutional and legislative system. The research identified three key RSPs which impacted on

legislative attempts to reform the system: (i) the requirement for draft laws to be approved within certain time limits; ii) the possibility to accumulate additional draft laws to a previously submitted legislative proposal; and (iii) the existence of an 'urgency procedure' to fast track certain measures through the legislative process. These RSPs become visible at different moments of the reform process.

Thus, draft law PL180/2004S was submitted on 10<sup>th</sup> of March 2004 by Senator Germán Vargas Llera, who had a close relationship with the National Academy of Medicine (*Academia Nacional de Medicina*) (Largo-Arteaga, 2004). The dominant coalition restored to making use of the complexities of the law making process in Colombia, in order to prevent the successful conclusion of new legislation within a single legislature. In what clearly was a delaying strategy, the very late submission of draft laws PL236/2004S (by a group of Senators from President Uribe's political party) and PL241/2004S (developed by the Ministry of Social Protection) on 4<sup>th</sup> of June 2004 and the decision to discuss them jointly with PL180/2004S ended up delaying the process. The legislative period ended on 20<sup>th</sup> of June 2004 before the draft laws were approved in first parliamentary debate, and so they were abandoned (Hernández, 2005).

In 2004, a second wave of proposed reforms began with 11 draft laws submitted to Congress, starting with PL19/2004S, which reflected the beliefs and solutions of the 'opposing outsider coalition'. This was followed by PL31/2004S, submitted on 22<sup>nd</sup> July 2004 by Senators from President Uribe's party and PL33/2004S, which aligned with the views of the medical profession, submitted 5 days later by senator Germán Vargas Llera. Following, on 4 August, the government submitted PL52/2004S, to which all the other

11 initiatives were accumulated, under the justification of collating and conciliating all these initiatives (the previous and others that followed PL52/2004S such as PL98/2004S registered on 26 August and PL 151/2004S registered on 26 October). While these had been submitted early in the legislature, however, the very watered-down PL52/2004S got stalled at the Congress, where health insurers managed to orchestrate a strong opposition to it, with the support of the Ministry of Finance. Eventually, other legislative priorities such as pension reform and the presidential elections delayed PL52/2004S (and its accumulated draft laws), which did not progressed through the legislative process before the end of the legislature on 20<sup>th</sup> June 2005 and ended up being abandoned (Guzmán, 2006).

The 2010 wave of draft laws started with PLE 186/2010 introduced jointly by the Minister of Social Protection Mauricio Santamaría and Minister of Finance Juan Carlos Echeverry on 29<sup>th</sup> October 2010, and projects PLE189/2010S, PLE198/2010S and PLE131/2010C were later accumulated to it. PLE 189/2010S was registered on 4<sup>th</sup> November by Senator Holger Horacio Díaz, whose proposals reflected the position of the medical associations and PLE198/2010S was registered on 19<sup>th</sup> November by Senator Luis Carlos Avellaneda. Being statutory draft laws, all these had to proceed through Parliament in a single legislature (before the 20<sup>th</sup> June 2011); having failed to do so, they had to be abandoned.

Finally, four draft statutory laws (PLE 48/2012S; PLE 59/2012C; PLE 105/2012S; and PLE 112/2012S) reflecting the views of the different actors, were registered in Parliament once the legislature started on 20<sup>th</sup> July 2012 and were bundled together for discussion

simultaneously. However, as statutory draft laws, they needed to be processed through Parliament in a single legislature. However, as this did not happen before the end of the legislature on the 20<sup>th</sup> June 2013, they had to be abandoned.

In sum, none of the four waves of draft laws submitted to Congress which aimed to introduce significant reforms the health system came to fruition. Arguably, the status quo was maintained by the dominant coalition, which managed to block any potential reforms either with the support of the Ministry of Finance or by taking advantage of the lack of enthusiasm and commitment to reform within the Ministry of Health, even for their own policy proposals. Congressional rules of procedure – i.e. the requirement that all ordinary draft laws need to be approved at least in a first debate within a single legislative period and, and for statutory draft laws to be fully expedited within a single legislature – was used strategically by actors to block unfavourable proposals. New draft laws were accumulated for discussion, delaying the debate on the initial proposals, so that the whole batch of draft laws run out of time.

The use of the ‘urgency procedure’ as a mechanism to speed up the policy process and determine policy subsystem dynamics is visible at two key moments in the process. First, in 2010, the government promoted draft law PL01/2010S which was jointly debated with a long list of other projects accumulated to it (i.e. PL 143/2010S, PL 126/2010C, etc.) and requested the use of the ‘message of urgency’ to speed up the legislative process. Consequently, PL01/2010S was passed, successfully becoming Law 1438 in January 2011. Secondly, in 2013, draft Statutory Law PLE 209/2013S passed

through Parliament via the urgency procedure in just four months (although it got delayed later at the Constitutional Court), eventually becoming Statutory Law 1751.

In both cases, it was a resource in the government hands, either to neutralise some of the legislative initiatives that were being put forward and avoid fundamental reforms (clearly in the PL01/2010S case) or to regain policy leadership and momentum (as the use of the urgency procedure during the PLE209/2013S process suggests). In both cases, the process ended up with the rejection of the challenging coalitions, under the claim that their opinions and contributions had not been taken into account. Importantly though, neither Law 1438 nor Statutory Law 1751 have brought about significant modification of the building blocks of the existing health system.

## **Conclusion**

This article has explored the high level of contestation over the structure and organisation of Colombian health system since its inception in 1993, and the resilience of this system to substantial reform. The ACF has proved to be a useful analytical framework to understand the ongoing process of health reform in Colombia, by identifying the advocacy coalitions participating in the health policy subsystem and the ways in which they interacted with, and sought to influence, the reform process. The 20-year long process of attempting to reform the Law 100 reflects the ongoing competition between three advocacy coalitions to shape the health system in ways amenable to their underlying interests and values. These coalitions are centred on a set of deep core beliefs on: how the health system should be financed (by insurance contributions versus taxes); how involved the private sector should be in the managing of the system and the

provision of care services; whether limits can or should be placed to the right to health care; and what is the appropriate level of autonomy of the medical profession. We recognise that the account of the reforms put forward here does not represent the definitive account of the reforms and other approaches from different theoretical standpoints (for example, for an alternative socio-political analysis, see Hernández 2005; Hernández-Álvarez and Torres-Tovar 2010; and Vega-Vargas et al. 2012; for an actor-centred approach that looks into the political contention of state and societal actors, see Uribe 2009; for an explanation based on the role of the particular group of policy makers that promoted and led the health reforms – the “change team”- see González-Rosetti and Bossert 2000). However, it is beyond the scope of this article to discuss these in detail. We argue that the ACF provides a useful analytical tool through which to understand and make sense of these events, which contributes to this important debate in Colombian health policy.

Since the election of President Juan Manuel Santos in 2010, the emergence of two challenging coalitions has occurred in parallel with the weakening of the ‘dominant coalition’ and the gradual distancing of this coalition from successive ministers of Health Mauricio Santamaría (August 2010-January 2012) and Beatriz Londoño (January-September 2012) and, in particular, from Minister Alejandro Gaviria (from September 2012). Arguably, the difficulties experienced by Minister Gaviria’s legislative initiatives (draft Ordinary Law PL 210/2013S and later PL 24/2014S) and the strong criticisms received from all camps reflect the distance of the current ministerial team from the three main advocacy coalitions in health. Nevertheless, neither of the two challenger

coalitions has been powerful enough to override the hegemony of the 'dominant' coalition.

In applying the ACF, this study has shown the role of RSPs in conditioning the actions of advocacy coalition in health, thus supporting Montefrío's (2014) study that coalitions strategically use basic constitutional structures and mechanisms of the state to shape the policy process. Moreover, in applying the ACF to Colombia we contribute to the expansion of the ACF to new political context beyond its traditional focus on Europe and North America, thus addressing a key limitation identified in this framework (Henry et al. 2014). The analysis of the legislative proposals submitted to Congress between 1993 and 2014 has revealed how the dominant coalition has exploited the complex mechanisms of the law making process in Colombia for their own ends and used delaying tactics to impede new legislation being successfully passed by Congress. The reason why the Colombian health system has proven so resilient to reform has to be understood as a result of the antagonistic dynamics between advocacy coalitions within the health policy subsystem. Cross-coalition agreements between these antagonistic coalitions have not happened.

The 20-year history of attempts to restructure the system does not appear to be close to resolution. Health Minister Gaviria has stated that 80% of his proposed reform has already been achieved, not through the passing of an overarching law but by reforming particular aspects of the system through secondary legislation (Estilo de Vida, 2014). However, he is also aware of the lack of consensus over his reforms amongst key policy actors, so it seems likely that the subsequent attempts to reform the system lay ahead



for future times. Nevertheless, it appears likely that efforts to breach this impasse might not be any easier to achieve unless greater cross-coalition agreement first emerges on the basics principles of the system.

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## Annex I. Laws and project laws reviewed

### **1992-2010**

#### ***1993-2002***

- PLs that led to Law 100: PL155/1992S [+ PL 204/1992C]

#### ***2003-2004***

- PL180/2004S and accumulated: PL236/2004S; PL 238/2004S; PL241/2004S; PL 242/2004S
- PL 052/2004S and accumulated: PL 019/2004S; PL 031/2004S; PL 033/2004S; PL 038/2004S; PL 054/2004S; PL 057/2004S; PL 058/2004S; PL 098/2004S; PL105/2004S; PL 115/2004S; PL122/2004S; PL 151/2004S

#### ***2006-2007***

- PLs that led to Law 1122: PL 40/2006S [+ PL2/2006C] and accumulated PL 20/2006S; PL 26/2006S; PL 38/2006S; PL67/2006S; PL 116/2006S; PL 122/2006S; PL 128/2006S; PL 143/2006S; PL 1/2006C; PL 18/2006C; PL 84/2006C; PL 130/2006C; PL 137/2006C; PL 140/2006C; PL 141/2006C and PL01/2006S [+PL87/2006C]

### **2010-2015**

#### ***2010***

- PLs that led to Law 1438: PL01/2010S [+PL106/2010C] and accumulated: PL 095/2010S; PL 143/2010S; PL 147/2010S; PL 160/2010S; PL161/2010S; PL182/2010S; PL 087/2010C, PL 035/2010C; PL 111/2010C; PL 126/2010C
- PLE 186/2010S and accumulated: PLE 189/2010S; PLE131/2010C; PLE 198/2010S
- PL 229/2010S

#### ***2012***

- PLE 048/2012S and accumulated: PLE 059/2012C; PLE 105/2012S; PLE 112/2012S

#### ***2013-2014***

- PLEs that led to Law 1751: PLE 209/2013S [+PLE267/2013C]
- PL 210/2013S [+PL147/2013C] and accumulated: PL 233/2013S; PL 051/2012S

#### ***2014-2016***

- PLs that led to Law 1797: PL 77/2014S and accumulated PL 24/2014S [+ PL 109/2015C]

**Table I. Advocacy Coalitions of the Health Policy Subsystem in Colombia & beliefs towards the reform of the Law 100**

Name	Dominant coalition	Challenging Insider coalition	Opposing Outsider coalition
Coalition members	<ul style="list-style-type: none"> <li>Health insurers (EPS of both regimes and ‘Cajas de Compensación’                             <ul style="list-style-type: none"> <li>o ACEMI</li> <li>o Gestarsalud</li> <li>o Asocajas</li> </ul> </li> <li>Private health providers (IPS)</li> <li>Ministry of Finance</li> <li>Departamento Nacional de Planeación</li> <li>Ministry of Health (from 1993 to 2012)</li> <li>Legislators: Alvaro Uribe Vélez; Rafael Pardo</li> <li>Fedesarrollo</li> </ul>	<ul style="list-style-type: none"> <li>Academia Nacional de Medicina</li> <li>Asociación Colombiana de Sociedades Científicas</li> <li>Federación Médica Colombiana</li> <li>ASMEDAS</li> <li>Colegio Médico Colombiano</li> <li>Legislators: Germán Vargas Llera; Roy Barreras</li> <li>Asociación Colombiana de Hospitales y Clínicas (ACHC)</li> <li>Academia: academics from Universidad de Antioquia</li> <li>San Vicente Fundación</li> <li>Media: Journalists of newspaper El Tiempo</li> </ul>	<ul style="list-style-type: none"> <li>Association of medical interns and residents (ANIR)</li> <li>Social groups</li> <li>Legislators: Luis Carlos Avellaneda; Jorge Enrique Robledo</li> <li>Academia: Universidad Nacional; Universidad Libre</li> <li>ACESI</li> <li>Defensoría del Pueblo</li> <li>Media: El Espectador</li> </ul>
Coordination mechanism	<ul style="list-style-type: none"> <li>ACEMI – ‘La llave’</li> </ul>	<ul style="list-style-type: none"> <li>Gran Junta Médica (GJM)</li> </ul>	<ul style="list-style-type: none"> <li>Mesa Nacional por el Derecho a la Salud (100 organisations)</li> </ul>
Problem identification	<ul style="list-style-type: none"> <li>In favour of Law 100: the system has enough tools to tackle the current problems – what is missing is a proper regulation of the law.</li> <li>Financial problems: EPS lack of liquidity because central fund (FOSYGA) delays payments</li> </ul>	<ul style="list-style-type: none"> <li>Sustainability problems due to <i>tutelas</i> and <i>recobros</i></li> <li>EPS responsible: uncontrolled profit-seeking behaviour</li> <li>Lack of stewardship role</li> <li>There is nominal health coverage, but not effective universal health coverage</li> <li>Medical autonomy has been lost</li> </ul>	<ul style="list-style-type: none"> <li>EPS responsible: uncontrolled profit-seeking behaviour. Corruption.</li> <li>Lack of stewardship role</li> <li>There is nominal health coverage, but not effective universal health coverage</li> </ul>
Deep core beliefs	Efficiency and market competition with private sector participation.	<ul style="list-style-type: none"> <li>Self-regulated medical model within a publicly ensured system. Full doctors’ autonomy to take clinical decisions. Preferably public provision.</li> </ul>	<ul style="list-style-type: none"> <li>A State-led, public health system based on equity to ensure universal coverage</li> <li>Health is a fundamental right (as a condition of citizenship)</li> </ul>
Policy core beliefs	<ul style="list-style-type: none"> <li>Colombia’s health system is only sustainable through insurance.</li> <li>The right to health is a right to receive a service.</li> <li>There is a need to regulate the right to health: it is not an absolute right.</li> </ul>	<ul style="list-style-type: none"> <li>Private healthcare provision if non-for-profit. Networks of service providers</li> <li>Single payer fund</li> <li>Against healthcare service rationing</li> <li>Eliminate insurance intermediation (EPS to become mere administrators)</li> <li>Government: stewardship and regulation</li> </ul>	<ul style="list-style-type: none"> <li>Public provision (and eventually, non-for-profit private provision)</li> <li>Eliminate insurance intermediation</li> <li>Development of primary care level and public health</li> <li>Against healthcare service rationing</li> </ul>
Secondary aspects	<ul style="list-style-type: none"> <li>Incentives need to be aligned</li> <li>In favour of vertical integration (with limits)</li> <li>In favour of two-tier system for different parts of Colombia: direct public provision for remote areas</li> </ul>	<ul style="list-style-type: none"> <li>Against capita contracting</li> <li>Set minimum tariff to contract doctors’ services (‘Piso tarifario para contratar’)</li> </ul>	<ul style="list-style-type: none"> <li>Networks of service providers</li> </ul>

\* While this table aims to capture individuals and organisations that, through the interviews and documentary analysis, have been consistently associated with the different coalitions, it is not however suggested as a static picture. Membership to coalitions has certainly evolved over the 20-year period covered in this study and some of the position and beliefs of the actors mentioned in the table might have evolved over time. The analysis of whether and how each member might have evolved is beyond the scope of this paper.