# Comments

**David McKenzie:** Ensuring equitable access to health care is one of the most fundamental steps a government can take for increasing the quality of life of its citizens. Many Latin American countries face similar problems to Colombia in meeting this goal: lack of coverage of much of the population, budget constraints, and large reported inefficiencies in the public health system. Consequently, the rich discussion of the Colombian experience provided here by Gaviria, Medina, and Mejía represents an important contribution that has several lessons for other countries planning reforms.

The first key lesson to draw from this paper is the need to pay attention to the political economy of the reforms. The authors argue that the public supply of hospitals is downward inelastic. Further research is needed to uncover who in the political process would have the power to shut down underperforming hospitals and what incentives they would have to do so. Second, the paper highlights the importance of building the appropriate incentives into a reform. Colombia's reform apparently did not have much effect on hospital managers' incentives to operate effectively, and it may have lowered beneficiaries' incentive to work, since they would lose eligibility if they obtained work in the formal sector. Successful reform requires not only laying out what is to be done, but establishing the right incentives for the various actors to make the reform work.

Third, the difficulties faced by the authors in trying to evaluate the impact of the reform ex post highlight the value of proactive policy evaluation. Having before-and-after data for individuals with SISBEN scores close to the cut-off would allow for a more convincing difference-in-differences evaluation. Since prereform data are not available, the authors are forced to carry out an ex post evaluation based on cross-sectional data, using the length of residence in the current municipality as an instrument for whether an individual is enrolled under the subsidized regime. Their first-stage regressions show that this variable is clearly correlated with enrollment, but the exclusion restriction does not convince me.

The identifying assumption is essentially that, conditional on observable characteristics, being a migrant has no effect on health outcomes or labor force participation. The entire migration literature worries about exactly this problem, however, since migrants do self-select and are likely to differ from nonmigrants in terms of ability, vulnerability, health status, health knowledge, and all sorts of unmeasured factors. The main findings of the paper—namely, that those enrolled in the subsidized regime have better self-reported health and lower labor force participation—could just as easily be interpreted as saying that migrants have worse health and higher labor force participation. Since the desire to work may be one of the main motives for migration, people who moved to an area fairly recently may be more likely to be working than long-term residents. Since migrant jobs are often classified by the three Ds—dirty, dangerous, and difficult—migrants working in them may very well have worse health. Finally, since migrants may exhibit risky health behavior and use health facilities infrequently, they may present worse health outcomes than long-term residents even in the absence of the subsidized regime.

The fact that individuals were apparently using political connections to gain access to the subsidized regime suggests that they expected some benefit from the program. I therefore doubt that all of the positive effect found on self-reported health care and the use of medical services is driven by differences between individuals selected for the program and individuals not selected. An assessment of the reform's effectiveness requires accurate measurement of the size of the benefits, however, and well-measured and credible program impacts may serve as a tool for activists attempting to overcome the political barriers to further reform. Such programs should therefore build evaluation into the program design.

**Rodrigo R. Soares:** Gaviria, Medina, and Mejía discuss two important dimensions of the health reform in Colombia: the political economy of its proposal and implementation and the effectiveness of the new system as a tool for improving the health and welfare of the poorer population. My comment here addresses the authors' contribution on each of these two dimensions.

## The Political Economy of the Reform

The discussion of the political economy of Colombia's health reform highlights some of the pitfalls of ex ante assessments that ignore the specific institutional setting in which a reform is implemented. As in other cases of reform

in Latin America, Colombian reformers were overly optimistic regarding the evolution of the economy and their own capacity to deal with the institutional constraints of the public health system. The projected expansion of the formal economy was exaggerated, implying a forecast growth in formal employment and, therefore, in enrollment in the contributive regime that far surpassed actual growth. This mistake, which seems to have been anticipated by some of the program's critics, led to private underfunding of the subsidized regime, which resulted in a lower-than-expected expansion of the population covered.

The reformers' second mistake was overestimating the institutional flexibility of the Colombian public health system. At the national level, transition between the old and new systems required dismantling the previous public hospital system, either through closure of some public hospitals or through their migration from a system of supply-side subsidies to a system of demand-side subsidies, in which the transfers to each hospital would depend on the services it provided to the population enrolled in the new system. As the authors stress, the government was entirely unable to dismantle the supply-side subsidy system. This was partly due to the low growth of the contributive regime, which limited the possibility of expanding the subsidized regime. Given the low coverage of the subsidized regime, supply-side subsidies had to be kept in place for the uncovered population to have access to some type of health care. In addition, the closure of hospitals or the imposition of new efficiency standards proved to be a much more difficult political task than anticipated. Entrenched groups were able to exert political influence, and the expenditures on supply-side subsidies to public hospitals actually increased during the implementation period of the reform.

The authors tell a compelling story about the political economy involved in the reformers' excessively optimistic forecasts and the government's incapacity to implement some of the initial plans for institutional restructuring. These are shortcomings of any institutional reform, and they must have taken place, in more or less similar forms, in various other cases across Latin America. The Colombian case thus provides important markers for the analysis of the consequences and potential limitations of institutional reforms in other settings.

The only limitation of the authors' interpretation is to associate these political pitfalls intrinsically with reforms that aim to shift financing toward demand-side subsidies (such as school vouchers). These political restrictions appear in any context of institutional reform in which the approval of the reform itself is under negotiation and in which the implementation of the reform implies losses

for entrenched groups. This is always the case, independent of the particular principle involved in the reform under consideration; it is not specific to reforms aiming at subsidy-to-demand mechanisms. Moreover, to say that one might just learn to live with public supply is equivalent to saying that any political reform is impossible because of the political difficulties involved. Acknowledging the political constraints that inevitably have to be faced in any reform is not synonymous with accepting these constraints as given and immutable. Efficient reforms should be able to take these constraints into account and to lessen political resistance to reforms that are indeed welfare enhancing although they may be harmful to a relatively small, localized group.

## The Impact of the Subsidized Regime

The second part of the paper analyzes the effect of participating in the subsidized regime on family health outcomes and other dimensions of household decision making and welfare. Since enrollment in the program depends partly on individual initiative (because enrollment was rationed and perhaps bureaucratically costly), individuals may have self-selected into the program based on either necessity (health status) or political influence (connections). In the former case, the endogeneity of selection into the program would probably lead to an underestimation of the subsidized regime's effects, since individuals in greater need of medical care would be more likely to be enrolled than healthy individuals. In the latter case, the endogeneity would probably result in an overestimation of the effects, since relatively wealthier (and healthier) individuals would be more likely to be enrolled (assuming that political influence is correlated to income or wealth).

To address this problem, the authors propose an instrument that supposedly affects the political influence of the individual but is not linked to his or her individual health status: namely, the number of years the individual has lived in the municipality. If connection with the local community is related to this variable, individuals who have lived in a municipality for a long time (conditional on age and other individual characteristics) should be more likely to be enrolled than recent arrivals, independent of their income or current health status. The authors show that this instrument performs well in a first-stage regression controlling for other individual characteristics, and they use it to analyze the impact of enrollment in the subsidized regime on different measures of health status, use of health services, consumption and living standards, and labor force participation.

The results of the exercise suggest that the subsidized regime increased the subjective health assessment of the families, increased the use of preventive consultations, and reduced hospitalizations. The authors find no effect on the number of days that individuals were unable to perform regular activities. Nevertheless, the results seem very consistent with the hypothesis of improved health stemming from greater access to medical services, combined with a rationalization in the provision of these services (that is, a shift from hospitalizations to preventive consultations). The insignificant coefficient on the number of days that individuals were unable to perform regular activities may reflect the fact that this analysis is conditional on the individual having had days of incapacitation. In other words, the authors are analyzing whether, given that the individual could not perform regular activities at some point during the year, the subsidized regime tended to reduce the number of incapacitated days. This strategy ends up greatly reducing the sample and restricting it to individuals who were indeed subject to some type of medical affliction. In this respect, the probability of being incapacitated at some point during the year (possibly analyzed using a probit model, including the entire sample) would be a more natural indicator and might generate distinct results.

The other set of empirical results from the paper is related to the impact of enrollment in the subsidized regime on several measures of household living standards. The authors find that enrollment is associated with reduced labor supply by women and, when the sample is restricted to poorer populations (SISBEN levels 1 and 2), to reduced household consumption. I would be somewhat cautious in interpreting the results for labor supply. According to the estimates, the average reduction in female labor supply is around 40 percent. For this change to be explained by the decision of female heads of household to forego formal employment to remain in the subsidized regime, the number of households headed by women and the response of these women to the system would have to be very large. The authors indicate that the formal employment of any member of the household makes the decision of a second member irrelevant in terms of eligibility for the subsidized regime. Therefore, any woman who does not head the household and is married to a man with formal employment should not be affected. The magnitude of these estimates is large enough to warrant caution—omitted variables or some other dimension of selection may be playing a role here.

The same care should be exercised when discussing the results on consumption in the restricted sample. As the authors point out in a footnote, their definition of consumption does not include durable goods or education. The income released from health expenditures could conceivably increase dis-

posable income to a point where the household decides to substitute previously consumed goods by more efficient durable goods. This would be the case if, for example, the family modified their daily food purchases to buy a refrigerator, offsetting the cost by switching to more concentrated and possibly cheaper food stuffs. Though this specific example may or may not seem reasonable, depending on the circumstances analyzed, there are margins over which the household can substitute certain daily consumption for certain durable goods. Moreover, other measures of household living standards generate different results from consumption. In the case of the conditions in the home, the analysis of the restricted sample of SISBEN levels 1 and 2 (the same sample for which the consumption results are significant) indicates that enrollment in the subsidized regime improves the conditions at home. In light of this, I would be cautious interpreting the negative effects of enrollment on consumption.

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