Document of

The World Bank

FOR OFFICIAL USE ONLY

Report No: PAD3489

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROGRAM APPRAISAL DOCUMENT FOR A PROPOSED LOAN IN THE AMOUNT OF

US$150.0 MILLION

AND A GRANT FROM THE GLOBAL CONCESSIONAL FINANCING FACILITY IN THE AMOUNT OF

US$37.60 MILLION

TO THE

REPUBLIC OF COLOMBIA

FOR

IMPROVING QUALITY OF HEALTH CARE SERVICES AND EFFICIENCY IN COLOMBIA PROGRAM

February 27, 2020

Health, Nutrition & Population Global Practice
Latin America And Caribbean Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective December 31, 2019)

Currency Unit =	Colombian Pesos
US$1 =	COP 3,285

GOVERNMENT FISCAL YEAR
January 1 - December 31

Regional Vice President:	J. Humberto Lopez (Acting)
Regional Director:	Luis Benveniste
Country Director:	Ulrich Zachau
Practice Manager:	Michele Gragnolati
Task Team Leader(s):	Roberto F. Iunes, Jeremy Henri Maurice Veillard

ABBREVIATIONS AND ACRONYMS

ADRES	Administrator of the Resources of the General System of Social Security in Health *(Administradora de los Recursos del Sistema General de Seguridad Social en Salud)*
BDUA	Unified Database of Affiliation *(Base de Datos Única de Afiliados)*
CAC	High Cost Account *(Cuenta de Alto Costo)*
CBA	Cost-Benefit Analysis
CGR	Comptroller General of the Republic *(Contraloría General de la República)*
CME	Continuing Medical Education
CONPES	National Council of Economic and Social Policy *(Consejo Nacional de Política Económica y Social)*
COP	Colombian Pesos
CPF	Country Partnership Framework
DALYs	Disability Adjusted Life-Years
DANE	National Department of Statistics *(Departamento Administrativo Nacional de Estadística)*
DFS	National Direction of Health Sector Financing *(Dirección de Financiamiento Sectorial)*
DLI	Disbursement Linked Indicator
DLR	Disbursement Linked Result
DNP	National Planning Department *(Departamento Nacional de Planeación)*
EFO	Externally Financed Outputs
EPS	Health Insurance Company *(Entidad Promotora de Salud)*
ESSA	Environmental and Social Systems Assessment
FSA	Fiduciary Systems Assessment
GCFF	Global Concessional Financing Facility
GDP	Gross Domestic Product
GoC	Government of Colombia
GRS	Grievance Redress Service
HCW	Health Care Waste
IBRD	International Bank for Reconstruction and Development
IFC	International Finance Corporation
INAP	Integrated National Adaptation Program
IPS	Health Care Provider *(Instituto Prestador de Salud)*
IVCS	Inspection, surveillance and sanitary control *(Inspección, Vigilancia y Control Sanitario)*
MADS	Ministry of Environment and Sustainable Development (*Ministerio de Ambiente y Desarrollo Sostenible*)
MHCP	Ministry of Finance *(Ministerio de Hacienda y Crédito Público)*
MIPG	Integrated Planning and Management Model *(Modelo Integrado de Planeación y Gestión)*
MoC	Memorandum of Collaboration with CGR
MSPS	Ministry of Health and Social Protection
NCDs	Non-communicable Diseases
NPV	Net Present Value
OECD	Organisation for Economic Co-operation and Development
PAPSIVI	Psychosocial and Integral Health Care for Victims Program *(Programa de Atención Psicosocial y Salud Integral a Víctimas*)

PAP	Program Action Plan
PBS	Health Benefits Package *(Plan de Beneficios en Salud)*
PDO	Program Development Objective(s)
PEP	Special Permit of Permanence *(Permiso Especial de Permanencia)*
PforR	Program for Results
PHC	Primary Health Care
PHCPI	Primary Health Care Performance Initiative
POM	Program Operational Manual
POS	Mandatory Health Insurance (*Plan Obligatorio de Salud*)
PLR	Performance and Learning Review
PND	National Development Plan *(Plan Nacional de Desarrollo)*
PPSS	Policy of Social Participation in Health (*Politica de Participación Social en Salud*)
PQRSD	Mechanism for Petitions, Complaints, Claims, and Suggestions *(Peticiones, Quejas, Reclamos, Sugerencias y Denuncias)*
RESPEL	Registry of Generators of Waste or Hazardous Waste (*Registro de Generadores de Residuos o Desechos Peligrosos*)
SDGs	Sustainable Development Goals
SGSSS	General System of Social Security in Health *(Sistema General de Seguridad Social en Salud)*
SIIF	Integrated Financial Information System (*Sistema Integrado de Información Financiera*)
SISBEN	System of Identification of Potential Beneficiaries of Social Programs (*Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales)*
SISDIS	Medical Device Price Reporting System *(Sistema de Reporte de Precios de Dispositivos Médicos)*
SISMED	Drug Price Information System *(Sistema de Información de Precios de Medicamentos)*
SISPI	Indigenous System of Own Intercultural Health (*Sistema Indígena de Salud Propio e Intercultural*)
SISPRO	Social Protection Integrated Information System *(Sistema Integrado de Información de la Protección Social)*
SIVIGE	Integrated Gender Violence Information System (*Sistema Integrado de Información de Violencias de Género)*
SNS	National Health Superintendence *(Superintendencia Nacional de Salud)*
SPF	State and Peacebuilding Fund
SOGC	Mandatory Guarantee System for Quality of Care *(Sistema Obligatorio de Garantia de la Calidad)*
SSA	Deputy Directorate of Environmental Health *(Subdirección de Salud Ambiental)*
TA	Technical Assistance
UHC	Universal Health Coverage
UNHCR	United Nations High Commissioner for Refugees
UPC	Capitation Payment Unit (Unidad de Pago por Capitación)
WBG	World Bank Group
WEEE	Waste from Electrical and Electronic Equipment
WHO	World Health Organization

DATASHEET

BASIC INFORMATION

Country(ies)	Project Name
Colombia	Improving Quality of Health Care Services and Efficiency in Colombia

Project ID	Financing Instrument	Does this operation have an IPF component?
P169866	Program-for-Results Financing	No

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Fragile State(s)
[ ] Contingent Emergency Response Component (CERC)	[ ] Fragile within a non-fragile Country
[ ] Small State(s)	[ ] Conflict
[ ] Alternate Procurement Arrangements (APA)	[ ] Responding to Natural or Man-made Disaster

Expected Project Approval Date	Expected Closing Date
19-Mar-2020	31-Mar-2023

Bank/IFC Collaboration	
No	Historical Project/Activity implemented in sequence with an IFC activity(Loan/Credit/Guarantee/AAA)

Proposed Program Development Objective(s)

The Development Objective of the Program is to support improvements in the quality of health care services and in the efficiency of the health system

Organizations

Borrower :	Republic of Colombia
Implementing Agency :	Ministry of Health and Social Protection

Contact:	Ivan Dario Gonzalez
Title:	Vice Minister
Telephone No:	573143827544
Email:	pbernal@Minsalud.gov.co

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	35,000.00
Total Operation Cost	1,983.00
Total Program Cost	1,983.00
Total Financing	1,983.00
Financing Gap	0.00

Financing (USD Millions)

Counterpart Funding	**1,795.40**
Borrower/Recipient	1,795.40
International Bank for Reconstruction and Development (IBRD)	**150.00**
Trust Funds	**37.60**
Global Financing Facility	37.60

Expected Disbursements (USD Millions)

Fiscal Year	2020	2021	2022	2023
Absolute	28.13	45.31	18.75	57.81
Cumulative	28.13	73.44	92.19	150.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the program plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Low
4. Technical Design of Project or Program	Low
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Low
9. Other	Substantial
10. Overall	Substantial

COMPLIANCE

Policy

Does the program depart from the CPF in content or in other significant respects?

[ ] Yes [✔] No

Does the program require any waivers of Bank policies?

[ ] Yes [✔] No

Legal Operational Policies

	Triggered
Projects on International Waterways OP/BP 7.50	No
Projects in Disputed Areas OP/BP 7.60	No

Legal Covenants

Sections and Description

Financing Agreement, Schedule 2, Section I, A.1. Implementation Arrangements.

The Borrower, through the MSPS shall operate and maintain throughout Program implementation a Program team with staffing and functions as set forth in the Program Operational Manual.

Sections and Description

Financing Agreement, Schedule 2, Section I, A.2. Implementation Arrangements.

Without limitation to Article 3.01 of the Loan Agreement, and to facilitate the carrying out of the Program, the Borrower shall, through MSPS: (i) be responsible for the execution of the Program as set forth in the Operational Manual; and (ii) pursuant to the Health Legislation: (1) ensure that the Program Entities carry out the Program activities under their respective mandates; and (2) transfer part of the proceeds of the Financing to the Program Entities to finance the pertinent Program Expenditure.

Sections and Description

Financing Agreement, Schedule 2, Section I, B.1. Implementation Arrangements.

The Borrower, through MSPS, shall adopt and thereafter carry out the Program, and cause the Program to be carried out, in accordance with the provisions of a manual (the Program Operational Manual or POM) satisfactory to the Bank, containing, inter alia: (a) the activities and timetable of actions to be carried out under the Program; (b) the respective roles and responsibilities of entities participating in the Program; (c) the composition and responsibilities of the Program team; (d) the fiduciary, technical and operational aspects and procedures for implementation of the Program, including the financial management procedures; (e) the performance indicators for the Program; (f) the verification protocols for the DLIs and DLRs, (g) the Anti-Corruption Guidelines; and (h) the Program Action Plan.

Sections and Description

Financing Agreement, Schedule 2, Section III. Program Monitoring, Reporting and Evaluation.

The Borrower shall furnish to the Bank each Program Report not later than forty-five days after the end of each calendar semester, covering the calendar semester.

Sections and Description
Financing Agreement, Schedule 2, Section I, B.2. Implementation Arrangements.
The Borrower, through MSPS, shall not amend or waive or fail to enforce any provision of the Program Operational Manual without the Bank's prior written approval. In case of any conflict between the terms of the Program Operational Manual and those of the Loan Agreement, the terms of the Loan Agreement shall prevail.

Sections and Description
Financing Agreement, Schedule 2, Section I, C. Implementation Arrangements.
The Borrower shall carry out the Program Action Plan, in accordance with the schedule set out in the said Program Action Plan in a manner satisfactory to the Bank.

Sections and Description
Financing Agreement, Schedule 3. Commitment-Linked Amortization Repayment Schedule – Bullet Repayment.
The Borrower shall repay the principal amount of the Loan in full on January 15, 2040.

Conditions

Type	Description
Effectiveness	Financing Agreement, Article V, 5.01. (a): The Program Operational Manual has been adopted in a manner and with contents acceptable to the Bank.
Effectiveness	Financing Agreement, Article V, 5.01. (b): The Memorandum of Collaboration has been signed.
Disbursement	Financing Agreement, Schedule 2, Section IV. B. 1 (a): Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made from the Financing Account unless each withdrawal is made on a pari passu basis and at a 80%:20% ratio between the amount of the Loan allocated to the pertinent DLR and the amount of the Concessional Portion of the Financing allocated to said DLR.
Disbursement	Financing Agreement, Schedule 2, Section IV. B. 1 (b): Notwithstanding the provisions of paragraph (a) of this Section, on the basis of DLRs achieved prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed $37,500,000 from the Loan and $9,400,000 from the Concessional Portion of the Financing may be made on the basis of DLRs, DLR (1) under Category (1), DLR (1) under Category (3) and DLR (1) under Category (4) , achieved prior to this date but on or after June 1, 2019.

Type	Description
Disbursement	Financing Agreement, Schedule 2, Section IV. B. 1 (c): Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made for any DLR under Categories (1), (2), (3) or (4) , until and unless the Borrower has furnished evidence satisfactory to the Bank that said DLR has been achieved.
Type	Description
Disbursement	Financing Agreement, Schedule 2, Section IV. B. 2: Notwithstanding the provisions of paragraphs (a) and (b) of this Section, the Borrower may withdraw an amount not to exceed $7,500,000 from the Loan and $1,880,000 from the Concessional Portion of the Financing as an advance; provided, however, that if the DLRs in the opinion of the Bank, are not achieved (or only partially achieved) by the Closing Date, the Borrower shall refund such advance to the Bank promptly upon notice thereof by the Bank. Except as otherwise agreed with the Borrower, the Bank shall cancel the amount so refunded. Any further withdrawals requested as an advance under any Category shall be permitted only on such terms and conditions as the Bank shall specify by notice to the Borrower.

IMPROVING QUALITY OF HEALTH CARE SERVICIES AND EFFICIENCY IN COLOMBIA

TABLE OF CONTENTS

I. STRATEGIC CONTEXT

A. Country Economic Context

1. **Colombia's economic growth has begun recovering gradually since mid-2017, supported by sound fiscal and monetary policies.** A robust macroeconomic policy framework has enabled orderly fiscal and external adjustments to the significant external shocks experienced over the mid-2014-2015 period. Growth had fallen to 1.4 percent in 2017, before accelerating gradually to 2.6 percent in 2018. Lower inflation and a slightly accommodative monetary stance supported a recovery in consumer confidence and private consumption. Economic growth is expected to accelerate gradually to 3.3 percent this year, and further to 3.6 percent in 2020.

2. **While the authorities remain committed to a fiscal adjustment path consistent with Colombia's fiscal rule, tax reforms approved over the past years have not yet generated a much-needed structural increase in revenues.** Colombia has a fiscal rule, which mandates a reduction of 1.5 percentage points of Gross Domestic Product (GDP) in the central Government fiscal deficit between 2018 and 2022, which is equivalent to cutting the structural deficit of the central Government to 1 percent of GDP by 2022. The Fiscal Rule Consultative Committee allowed an additional space of 0.5 percent of GDP to accommodate migration-related spending. This additional spending would decline gradually over time as a share of GDP. Thus, the fiscal deficit allowed under the fiscal rule is 2.7 percent in 2019. However, the Government is targeting a deficit of 2.4 percent of GDP, to be achieved primarily through spending cuts. Additional fiscal consolidation measures may be needed in 2020.

3. **The on-going process of peace consolidation and the large migration inflow from Venezuela generate significant additional fiscal pressures.** Post-conflict spending commitments – which according to Government estimates may cost approximately 0.7 percent of the GDP per year – and spending related to the migration flows from Venezuela, together with the need to ensure enough public investment to support medium-term growth, put pressure on Colombia's tight fiscal space. As of October 31, 2019, there were 1.63 million Venezuelans in Colombia, including about 719,000 regular migrants. Many of these migrants are not only income poor but also come to Colombia with acute health care needs, as a result of the collapse of the Venezuelan health system. It is estimated that, in 2018 alone (when migration numbers were still lower), between 0.26 percent and 0.41 percent of GDP would have been required to provide access to services to the returnees and eligible migrants at a level similar to that provided to the local population. This implies that additional fiscal consolidation measures over the 2020-2022 period will be necessary, including targeted expenditure containment and rationalization, as well as efficiency-enhancing measures.

4. **The Government of Colombia (GoC) concluded the formulation and approval of the 2018-2022 National Development Plan (*Plan Nacional de Desarrollo*, PND)**. With a projected investment of approximately COP 550 trillion (around USD 180 billion) for the next four years – 50 percent of the Government's pluriannual investment plan for the period – the PND seeks to increase capital formation and multifactor productivity, which are expected to increase the country's potential growth. The PND aims to: (a) reduce monetary poverty by 2.9 million people (thus reducing the monetary poverty rate from the current 27 percent to 21 percent in 2022); (b) reduce the population in extreme poverty by 1.5 million people (from 7.4 percent currently to 4.4 percent in 2022); (c) reduce the population in multidimensional

poverty by 2.5 million people (from 17 percent to 11.9 percent in 2022); and (d) create 1.6 million additional jobs during the four-year period of its implementation.

B. Sectoral (or Multi-Sectoral) and Institutional Context

5. **The Colombian General System of Social Security in Health (*Sistema General de Seguridad Social en Salud*, SGSSS) provides almost universal insurance coverage and a significant level of financial protection to its beneficiaries and is regarded as one of the country's major social achievements of the last decades.** The increase in health insurance coverage achieved after the approval of the 1993 health reform (Law 100), from 23.5 percent in 1993 to around 94-96 percent since 2010, had a particularly large impact on the poor: during 1997 to 2016, health insurance coverage for those in the lower income quintile increased from 42 percent to approximately 93 percent and from almost 48 percent to 93.5 percent for those in the second quintile. Nevertheless, insurance coverage among migrants remains low. Although registered migrants are eligible to the SGSSS, only 29 percent of those eligible are currently affiliated and only 35.8 percent of those are enrolled in the subsidized regime. In addition, indigenous groups in frontier areas[1] are potentially eligible to the SGSSS but need to be recognized by the relevant indigenous authorities so that their rights can be exercised, which constitutes an additional barrier to coverage.

6. **The SGSSS functions through a strategy of managed competition aimed at promoting efficiency and quality**. At the first tier, health insurance companies (*Entidades Promotoras de Salud*, or EPSs) compete for consumers in terms of the quality of the services offered, as every citizen is free to choose the health plan in which he or she wishes to enroll. EPSs cannot compete on price, for each of them derives its revenues from the per capita price or premium fixed by the Government known as *Unidad de Pago por Capitación* (UPC) multiplied by the number of persons that it insures. The value of the UPC takes into account age, sex and place of residence of the population, and is defined annually. At the second tier, health care providers (*Instituciones Prestadoras de Salud* or IPSs) compete to be contracted by the EPSs on the basis of price-quality combination.

7. **The SGSSS is structured around two main insurance schemes or regimens under the responsibility of EPSs.** The contributive regime for salaried, pensioned and independent workers and the subsidized scheme for the low income, vulnerable, displaced and incarcerated populations.[2] The subsidized regime is the focus of this Program for Results (PforR). Law 100 decentralizes the planning function for health care services to departments and municipalities (*Entidades Territoriales*) that also supervise public hospital service delivery.

8. **The Colombian legislation assigns to the Ministry of Health and Social Protection (*Ministerio de Salud y Protección Social*, MSPS), fundamentally, the role of steward of the health sector, while the insurance function is the responsibility of the EPSs and the delivery of care of the IPSs and departments.** The roles and functions of the MSPS include the formulation and evaluation of policies, plans, programs and projects related to patient protection, promotion and prevention, health insurance and professional risks, provision of services and primary health care (PHC), financing and information systems. As well as

[1] Wayuu (La Guajira), Kurripako (Guainía, Vaupés and Vichada), Piapoco (Vichada), Yukpa (Cesar – Serranía del Perijá), Puinave (Guainía, Vichada y Guaviare), Saliba (Casanare and Vichada), Piaroa (Vichada) and Sikuani (Vichada, Meta, Casanare).
[2] There is also a third scheme, known as the special benefit regime, that includes the armed forces, teachers, some public universities and ECOPETROL (the state-owned oil company).

the formulation, adoption and evaluation of policies related to pharmaceuticals, medical devices and supplies and biomedical technology. The MSPS also has the responsibility of developing and implementing mechanisms and strategies aimed at optimizing the use of these inputs. The activities related to the fulfillment of these roles and functions are developed through the institutional framework of its administrative sector.

9. **Some of Colombia's main health outcomes show important progress in recent years, but due to the demographic and epidemiological transitions, the country is simultaneously experiencing a rapid increase in the prevalence of non-communicable diseases (NCDs), which contribute to growing concerns regarding the financial sustainability of the SGSSS.** Chronic malnutrition, adolescent pregnancy and vaccination coverage have all shown substantial improvements. Colombia also has one of the most comprehensive immunization programs in Latin America. However, as the population ages and is increasingly exposed to health risks factors such as poor dieting, smoking, drinking and sedentary habits, NCDs have become the main cause of death and disability. As the treatments of chronic diseases are more complex and expensive, the increased burden of NCDs has contributed to the rapid growth of total health spending. In addition, the system's financial and economic strain is compounded by conjunctural elements such as the migratory process and the demands imposed by the peace agreements noted earlier. Breast cancer is a good tracer indicator for many of these issues. It impacts 2.1 million women each year and causes the greatest number of cancer-related deaths among women. In Colombia, breast cancer is responsible for almost 2 percent of the disease burden in women and more than 3 percent of all female deaths (14 percent of all cancer deaths in women). Breast cancer is associated with the prevalence of risk factors such as a diet rich in fat and low fiber, obesity, smoking and reproductive factors such as: late age at first pregnancy, non-practice of breastfeeding and the use of oral contraceptives. Lack of access to health services may be another factor explaining higher levels of cancer mortality from breast cancer. In addition, there is inequality in access to diagnostic and treatment of breast cancer, where women affiliated with the subsidized regime are less likely to have a screening mammogram and wait longer for diagnosis and treatment initiation. Women with early diagnosis (stages I and II), accounted for 44 percent of breast cancer cases detected in the contributive regime and for only 29 percent in the subsidized regime or in the uninsured population.

10. **Despite the efforts made towards the expansion of insurance and service provision coverage, significant issues remain, particularly those related to quality of health care and health system efficiency.** Much of the focus of the Colombian health policy agenda since the health reform of 1993 has been directed towards the expansion of insurance and service provision coverage. This model boosted the provision of curative care to the detriment of health risk management and health promotion and primary and secondary disease prevention. As a result, quality-related indicators, such as those associated with early cancer detection, hospital readmission rates, avoidable hospitalizations, pregnant women receiving prenatal care and newborns protected against tetanus remain below optimum levels and/or are lower than the regional average. In addition, improvement in health outcome indicators such as neonatal, infant and under-five mortality rates show results that are inferior to those observed in the region and Organization for Economic Co-operation and Development (OECD) averages, with its negative impacts on overall costs to the system. Furthermore, the system's financing structure may not adequately reflect the epidemiological risk structures and does not incorporate appropriate incentives to promote preventive services and the implementation of a more cost-effective PHC-based model necessary for the prevention and control of chronic diseases.

11. **The World Bank Group (WBG) has developed a baseline assessment of health care quality in public and private service delivery in Colombia to help the MSPS identify areas of strength and weaknesses in health care quality in the Colombian health system and present recommendations for better stewardship and management of quality of care**. The assessment covered both the public and the private sector and included a deep dive on hospital care, using the International Finance Corporation (IFC) quality assessment tool. The main recommendations from this assessment were that action should be taken to: (a) strengthen capacity for continuous quality improvement in the health sector; (b) strengthen the quality ecosystem in the sector including the policy and regulatory regime; (c) improve the rigor and use of information on quality to stimulate patient choice and peer learning for IPSs; (d) develop and implement an integrated care model focused on high-performing PHC to support the management of individuals with complex, chronic health care needs; and (e) improve accountability and contracting mechanisms to incent for quality.

12. **In addition, an in-depth assessment of the performance of the Colombia PHC system showed performance gaps in quality of care and effective coverage.** This assessment used the Primary Health Care Performance Initiative (PHCPI) framework and core indicators, including a maturity model to assess strengths of PHC policies and governance, availability and distribution of service delivery inputs, as well as the organization and management of PHC services. The PHCPI is a partnership of the WBG, the Bill and Melinda Gates Foundation, and the World Health Organization (WHO). Preliminary findings from this baseline assessment showed that even though Colombia has achieved high levels of access to PHC, results are not commensurate in effective coverage, pointing to two bottlenecks to system performance: the quality of care delivered and the equitable distribution of this care across the population. Although 75 percent of mortality in Colombia can be attributed to NCDs, effective care coverage for these illnesses is the largest bottleneck to effective service PHC coverage in Colombia: over 30 percent of the population has uncontrolled hypertension and 50 percent of diabetics have uncontrolled blood sugar levels. Coverage for essential infectious disease services and maternal and child health services are delivered to 85 percent or more of the population displaying important achievements but room for improvement.

13. **Challenges such as those related to the improvement and strengthening of pharmaceutical policies and to the growth in judicial claims related to health remain and impose a strain on the overall efficiency of the sector.** The cost of medicines represented, on average, approximately 21 percent of the SGSSS total health spending between 2007 and 2017, but until the early 2010s Colombia did not have a framework to regulate pharmaceutical prices. Since then, the MSPS has introduced several measures to improve and strengthen its pharmaceutical policies. However, results in terms of access to medicines and total spending have been mixed and the country still needs to further develop its capacity to supervise and monitor pharmaceutical services. The reimbursement, through judicial claims, of high-cost inputs (mostly medications), services and procedures not included in the benefit plan (*Plan Obligatorio de Salud*, POS, until 2016) have escalated in the past 10 years, from COP 600 billion in 2007 to COP 2.5 trillion in 2016, i.e. around 10 percent of total expenditure of the MSPS. The rapid growth in judicial claims related to health result in part from the perverse incentives presented to insurers and providers to grant services that are paid on a higher reimbursement schedule outside the UPC, but also from the inability of the system to fulfill some of its obligations.

14. **It is important to emphasize that, in addition to the financial pressure that it generates, the Venezuelan migration has a direct impact on the quality of health services and on the efficiency with**

which these services are provided The cost of providing health services to the more than 400,000 Colombians that have recently returned from Venezuela and the 719,000 eligible Venezuelan migrants – i.e. those with Special Permit of Permanence (*Permiso Especial de Permanencia*, PEP) – is substantial[3], thus putting additional pressure on the financing of the health system. In addition, contrary to traditional migratory processes, the current inflow, which increased markedly in 2018, is characterized by a very rapid arrival of people and a relatively high proportion of individuals in conditions of socio-economic vulnerability and requiring urgent or acute care, thus placing a major burden on health care facilities. Furthermore, the rapid increase in the demand for health services is concentrated in areas characterized by pre-existing deficits in service provision, such as the department of La Guajira, where 33 percent of the population have barriers to access health care services.[4] These characteristics of the migratory process create a significant strain on the quality, organization and efficient delivery of health care services.

Box 1. Impact of the Venezuelan Migration on the Colombian Health System

Given the social and economic situation in Venezuela and the deterioration of its health sytem, Venezuelan migrants tend to be highly vulnerable, with a large burden of disease. This has important implications for Colombia – in 2018 it was estimated that between 0.26 percent and 0.41 percent of the Colombian GDP would have been required to provide access to social services to the returnees and eligible migrants at a level similar to that provided to the local population – and the Colombian health system – the utilization of health services by Venezuelan migrants increased from 125 in 2014 to more than 18,000 in the first months of 2018. This is impact is particularly felt by the frontier departments where the Venezuelan migrants tend to concentrate, as these areas are already underserved, have higher incidence of multidimensional poverty than the rest of Colombia and have large proportions of Indigenous and Afro-descendant populations.

The GoC has dedicated much effort to extend health services to migrants. The MSPS developed in 2018 a "Health Sector Response Plan for the Migration Phenomenon," with the aim of managing the health response to the situation generated by the fast-increasing migration. In addition, in November of 2018, the Government announced the "Strategy for the Care of Venezuelan Migration," with the aim of developing a road map for the basic care of the migrants for the next three years, beyond humanitarian response actions. The GoC is trying to extend SGSSS coverage to all legal migrants and will fully subsidize the premiums for all those without ability to contribute. In addition, it offers emergency health services free of charge to all migrants, regardless of their migration status. These efforts are costly: in 2018, it was estimated by the MSPS that the total outlays of the public health sector to attend Venezuelan migrants reached about 115 billion Colombian pesos (about USD 35 million).

15. **Access to health care in remote areas remains difficult.** Geographic and financial barriers mostly affect people in remote areas where communication is difficult and transportation expensive. These areas also tend to be the same ones that are receiving a significant number of Venezuelan migrants and, because

[3] In 2018, the MSPS diverted approximately USD 7 million to public hospitals to help pay for the urgent care of Venezuelan migrants. Between August of 2017 and June of 2019, the MSPS spent an additional USD 6 million to purchase vaccines to immunize the migrant population (these costs do not reflect the total cost of the vaccination, as they do not include other inputs, personnel, transport, etc.).

[4] World Bank 2018. *"Migración desde Venezuela a Colombia: Impactos y Estrategia de Respuesta en el Corto y Mediano Plazo."*

they are generally poorer than other departments, they are unattractive to private insurers and providers. In this sense, the public sector plays a vital role in the coverage and provision of health services in these areas. This is becoming evident, for example, in post-conflict and migration areas, where the singular needs of local communities – e.g. those related to mental health issues and to the health needs of ex-combatants, displaced and other victims beneficiaries of the Psychosocial Care and Integral Health for Victims Program (*Programa de Atención Psicosocial y Salud Integral a Víctimas*, PAPSIVI)[5] and migrant families – require a vertically integrated model of care that is unlikely to be fulfilled by non-public providers.

16. **Finally, given its tropical geographic location, biodiversity and topography, Colombia is particularly vulnerable to climate change, with significant impacts on the health sector.** Climate change impacts, including observed and anticipated increases in temperature, rainfall, sea level rise and weather volatility, pose direct effects on health outcomes resulting from direct exposure to extreme temperatures (heat waves) and severe weather events, such as floods, storms, droughts or forest fires. In addition, climate change is expected to increase the incidence of vector-borne diseases such as malaria and dengue and damage the health service infrastructure. About 65 percent of Colombia's urban population have a high probability of infection by dengue or by dengue hemorrhagic fever and climate change impacts are expected to exacerbate such vulnerability[6]. (The losses of almost four billion US dollars and 82 percent of damages in the housing and infrastructure sectors caused by the "*La Niña"* phenomenon of 2010-2011 exposed Colombia's high social, economic and environmental vulnerability, as well as the country's lack of adaptation strategies.

C. Relationship to the CAS/CPF and Rationale for Use of Instrument

17. **The proposed Program supports improvements in quality and efficiency in the Colombian health system through a PforR instrument and is aligned with the WBG Country Partnership Framework[7] (CPF) for the Republic of Colombia FY16 – FY21 and the Colombia Performance and Learning Review (PLR).** The Program proposed would contribute to Pillar 2, Objective 3 of the CPF "enhance social inclusion and mobility through improved service delivery" by supporting the improvement in the quality of health care services and efficiency of spending in the health sector. The PLR has confirmed that the CPF pillars and objectives are well-aligned with the overall strategic areas of Colombia's new PND that the proposed Program will support.

18. **The proposed Program is also in line with the WBG's twin goals of eliminating extreme poverty and boosting shared prosperity by assisting Colombia to accelerate progress towards the achievement of Universal Health Coverage (UHC).** It is also closely aligned with the Sustainable Development Goals (SDGs) which stress the importance of achieving UHC and financial protection. The proposed Program is consistent with the Priority Directions of the Health, Nutrition and Population Global Practice 2016-2020 and aligned with the WBG's Human Capital Project, which calls for countries to make greater investments in health and education to improve the productive capacities of their populations.

[5] Program set out to address the psychosocial impacts and damage to the physical and mental health of the victims caused by or in relation to the armed conflict, in the individual, family and community spheres in order to mitigate their emotional suffering, contribute to physical and mental recovery and the reconstruction of the social fabric in their communities.
[6] *Colombia, DNP. Plan Nacional de Adaptación al Cambio Climático*, 2018.
[7] Report No. 135458-CO, discussed by the WBG Board of Executive Directors on May 21, 2019.

19. **The PforR instrument is the first lending operation that the WBG has had in the health sector in Colombia in more than 25 years.** The PforR instrument is appropriate for the proposed operation as the Government has a coherent program and since it provides an opportunity for relatively small external financing to leverage larger systemic changes, based on the achievement on results. The instrument is particularly suitable to support the operation as: (a) The goal of the proposed operation is directly aligned with the health sector goals of the PND 2018-2022; "Health for all with quality and efficiency, sustainable by all"; (b) Colombia has sound institutions and procedures; (c) by linking disbursements to achievement of results that are tangible, transparent, and verifiable, the PforR can be an effective instrument to shift focus towards the achievement of results, rather than concentrating on issues related to the financing of inputs; (d) the use of the PforR instrument will ensure that priority is given to key goals of the Government, shielding them from political uncertainties; (e) the PforR instrument will also allow for improvements, as necessary, in the implementation of Governments' own technical, fiduciary and safeguard systems; and (f) because the Government's program will also be supported by an operation financed by the Inter-American Development Bank (IDB) (see Box 2), the PforR instrument will ensure complementarity between the two projects and thus maximize the value added of external financing for the country.

Box 2. The IDB-financed Operation

The IDB financing is not parallel financing, but rather separate financing for which the Government is seeking to ensure complementarity between the WB loan and the IDB loan.

The IDB-financed operation is also results-based, focuses on efficiency and support to the financial sustainability of the SGSSS, and has three main components: (a) improve the management and control of expenses not financed by the UPC, such as those generated by new technologies that have not been incorporated into the benefit plan; (b) support the implementation of the Integral Territorial Action Model (*Modelo de Acción Integral Territorial*, MAITE), which seeks to strengthen local authorities and engage the community in the joint development of health plans to improve the health of the population; and (c) complementary to the WBG loan, this component will also support the affiliation of regularly registered Venezuelan migrants to the SGSSS. Duplication or double counting between the two operations will be avoided with the use of the Unified Database of Affiliation *(Base de Datos Única de Afiliados*, BDUA), which provides a unique identifier for each individual affiliated to the SGSSS.

II. PROGRAM DESCRIPTION

A. Government Program

20. **The program to be supported by this PforR is part of the Government's 2018-2022 PND.** The main objective of the Government's health sector program is to simultaneously improve the health status of the population, guaranteeing high standards of quality and satisfaction on the part of the users, as well as the optimal use of available resources. In order to achieve this triple aim, the Government program proposes the construction of a pact that allows all the agents of the health system and civil society, in a concerted manner and through clear commitments, to ensure that the health system is effectively leveraged as one of the priority accelerators for social mobility and equity. The Government's health sector program connects six broad objectives: (a) strengthen the stewardship and governance of the health system; (b) define public health priorities and interventions; (c) organize all health sector actors around the promotion of quality services; (d) invest in infrastructure and allocate resources to ensure

access and foster quality; (e) develop, strengthen and properly recognize the value of human resources for health; and (f) reach efficiency in spending through the optimal use of the resources available and the addition of new resources from all stakeholders (See Table 1). The PND allocates COP 119 trillion (USD 35 billion) for the period 2019 – 2022 of public resources to the health program.

21. **The PforR builds on a multi-year analytical engagement with the GoC on issues related to the financial sustainability, quality and efficiency of the health sector**. This work includes: the development of the Atlas of Geographic Variations in Health; the support to increase tobacco taxes; the study of multi-morbidities in Colombia; the assessment of the impact of migration in Colombia and response strategies; the technical assistance to strengthen the governance and financial management of the health system (with South Korea); the technical assistance in issues related to the judicialization of health (through the WBG's Collaborative Learning Initiative on the Right Health and UHC, "*SaluDerecho*"); and the three-phase RAS to support the National Health Superintendence *(Superintendencia Nacional de Salud, SNS)* in the development of a risk-based supervision model.

22. **The proposed PforR will provide an opportunity to maximize synergies with other investments and technical assistance provided by Development Partners**. The WBG and the IDB will provide financing to the GoC over the period 2020-2022 to support their ambitious program of reforms to improve the financial sustainability of the sector and improve quality of care. As mentioned above (see Box 2), the IDB financing is not a parallel financing but rather a separate financing for which the Government is seeking to ensure some complementarity between the WBG loan and the IDB loan. The financing instruments agreed upon by the GoC focus on achieving complementary results towards a common goal and will maximize technical assistance while minimizing the possible burden on staff of the MSPS.

Box 3. Technical Assistance

Technical assistance will be provided to the GoC to support of the achievements of the PforR results. In this regard, the WBG has opened a four-year international senior health specialist position in the country office to provide implementation support to the PforR and related engagement in the health sector. In addition, complementary technical assistance will be provided to the health sector from the PHCPI, the State and Peacebuilding Fund, and United Healthcare. Other collaborations and partnerships include collaboration with the Government of the Netherlands, the Government of South Korea, the Access Accelerated Trust Fund, *SaluDerecho*, the International Office for Migrations and the United Nations Refugee Agency (United Nations High Commissioner for Refugees, UNHCR).

Box 4. Collaboration with the Dutch Government

The organization and management of the Dutch health system presents many similarities to the Colombian health system: The Government carries out a stewardship function of the sector while the EPSs compete to provide care to their insurees based on quality and access to services. In particular, the Dutch health system has long developed advanced techniques in management and supervision of EPSs, ensuring that UPC is risk-adjusted to the risk profiles of insured patients, and ensuring that reliable and timely information on quality and access is available to citizens and patients to allow them to choose among competing EPSs. As part of this PforR, technical assistance will be provided by leading health experts and academics from the Netherlands, through joint support from the Dutch embassy in Colombia and the WBG. The technical assistance will focus on risk adjustment of the UPC to adjust to risk factors of the population insured; and on the measurement of patient experience and patient outcomes.

23. **In response to the enduring problem of gender-based violence, the PND has also defined a specific gender-related program area.** Data from the 2015 Demographic and Health Survey (*Encuesta Nacional de Demografía y Salud*, ENDS), show that 66.7 percent of women between 13 and 49 years of age surveyed and in a heterosexual union reported having suffered some type of violence in the last five years (64.1 percent responded that they had been victims of psychological violence, 31.9 percent of physical violence, 31.1 percent of economic violence and 7.6 percent of sexual violence by an intimate partner). For every man who claims to be a victim of violence by his partner, six women do so. The *Equity Pact for Women* present in the PND seeks to empower women, particularly in rural areas, by ensuring the inclusion of rural women in the processes of social and productive organization, in the provision of agricultural extension services, and access to credit, leading to an equitable and sustainable rural development. In addition, the pact seeks to strengthen the capacities of municipalities including health and social services at local level to prevent, address and protect women against gender-based violence. This includes training activities for municipalities, including health and social services professionals, and sensitivity to protect the privacy of female victims of gender-based violence and inform them about their rights to pursue legal action.

Table 1. Government program

Health for all with quality and efficiency, sustainable by all (PND: Health Pact)					
Objectives I, III, V and VI Quality and Efficiency related					
I. Stewardship and governance	II. Public Health	III. Quality	IV. Infrastructure and resources	V. Human Resources for Health	VI. Efficiency and financial Sustainability
Cross Cutting Program: Women's rights to live without violence (PND: Equity Pact for Women)					
Objective II. Institutional Strengthening to protect female victims of violence					

B. PforR Program Scope

24. **The proposed Program contributes directly to the health sector goals of Colombia's PND and to the strategic vision of the MSPS.** The goals of the proposed operation of improving quality and efficiency contribute, in the longer term, to strengthening the financial sustainability of the Colombian health system and, in this sense, mirror the title of the Government's health sector program supported by this PforR: "Health for all with quality and efficiency, sustainable by all." Furthermore, the proposed Program is highly consistent with the strategic vision of the MSPS, supported by the PND's objectives mentioned above.

25. **The boundaries defined for the PforR within the Government's 2018-2022 PND are presented in Table 2 below.** The PforR will support specific results under Objectives I, III, V and VI of the health program, and Objective II of the Pact for Women, that are related to improving quality and efficiency in the SGSSS.[8] The PforR will focus its assistance in the health sector stewardship and managerial functions of the MSPS and, as such, will support the development of policies and regulations required to achieve the Program's expected results during its three-year (2020-2022) implementation period. Focusing the PforR resources on these quality and efficiency related interventions will ultimately contribute to the financial sustainability of the health system and to improvements in population health, especially in women's health.

[8] The objectives of the Government program that are shaded in Table 2 are the ones that are not supported by the Program.

Table 2. Link between Government Program Objectives and PforR Results Area[9]

Government Program: Health for all with quality and efficiency, sustainable by all		PforR	
	Objectives	***Interventions and links to Results Chain***	***Results Area***
I	***Stewardship and governance***		
	A. Redesign the sector's inspection, surveillance and control model and strengthen the capacities in the territory. B. Improve the institutional framework of the health sector. C. Effectively shield the health sector from corruption risks and lack of transparency.	a. Update certification standards for health care facilities by level of care **(Disbursement Linked Indicator 1, DLI1).** b. Technical assistance (TA) for the development and roll out of pre-judicial agreement models aimed at addressing cases that can be resolved outside the court system. **(Intermediate Result; IR).** c. Address in a timely and responsive manner the requests, complaints, claims and suggestions posted by citizens **(IR)**.	***Quality and Efficiency***
II	***Public health***		
	A. Define priorities in public health according to the burden of disease. B. Implement public health interventions and lead, monitor and evaluate intersectoral actions to promote healthy policies.		
III	***Quality***		
	A. Strengthen authorization and accreditation systems for providers and insurers. B. Generate performance incentives for quality, efficiency and improvement of health outcomes. C. Redefine and implement a policy of service provision that guarantees quality and humanization of care with emphasis on optimizing the management of public hospitals. D. Operationalize the special models of attention at the local level, with a comprehensive approach for the patient and adjusted for rural areas with dispersed population. E. Promote tools that make quality and performance information available to users to empower them in decision making. *F. Foster health research (not supported under the PforR).*	d. Design the Mandatory Guarantee System for Quality of Care *(Sistema Obligatorio de Garantia de la Calidad,* SOGC). **(IR)**. e. Update accreditation standards for IPSs **(DLI1).** f. Design and introduce financial incentives for quality of care for cancer patients through ex-post adjustment of the UPC including the use of patient-reported outcome measures **(DLI 2)**. g. Design capacity building and training (pre service and in-service) plans in continuous quality of care for health workers (with focus on adherence to Clinical Practice Guidelines in targeted areas such as cancer) **(IR).** h. Update regulation for use of telemedicine to improve access to quality care **(IR).** i. Develop interoperability standards to improve clinical information exchange in real time between IPSs **(IR).** j. Provide TA to low-complexity hospitals to scale up the accreditation process **(IR).** k. Measure and publish public hospital performance results every trimester **(IR).** l. Ensure adequacy of training for human resources for health to better meet population health needs by	***Quality and Efficiency***

[9] The Program will support four out of six objectives under the Government program on Health, and one objective under the Gender Based Violence Pact for Women. In addition, the Program is supporting all the activities under these objectives with the exception of one; "foster health research", under Objective III – Quality.

Government Program: Health for all with quality and efficiency, sustainable by all		PforR	
	Objectives	***Interventions and links to Results Chain***	***Results Area***
		developing guidelines for the continuous quality improvement **(IR).**	
IV	***Infrastructure and resources***		
	A. Health care institutions equipped with adequate infrastructure and capacity to respond with quality and effectiveness to the needs of the entire population.		
V	***Human resources for health***		
	A. Close gaps in human resources in the health sector. B. Create and develop guidelines for closing gaps in quantity, quality and relevance of human resources for health at the territorial level. C. Implement continuous education strategies to develop and strengthen the competencies of health workers.	m. Develop capacity building plans for health workers with focus on protocols for service delivery and rights for repatriated, displaced population and migrants **(IR).**	***Quality***
VI	***Efficiency and financial sustainability***		
	A. Make health spending more efficient, through the updating of the benefit plan and other measures that make more efficient spending on technologies not financed by the UPC. B. Increase the funding sources of the SGSSS through the creation of a contribution to the health system as an alternative to extend the co-responsibility of the Colombian population, in accordance with their different payment capacities and through the acquisition of complementary private health insurance for higher income individuals. C. Reconcile and reorganize, in a progressive manner, the portfolio of health system agents, generating a change in financial practices that guarantees a definitive and structural reorganization of the debts of the sector.	n. Develop a prioritization methodology for the benefit plan based on burden of diseases, costs and impact with participation of citizens and scientific societies **(IR).** o. Based on *(n)* review the risk adjustment methodology for the capitation payment (UPC); and developing a technical document summarizing the recommendations **(DLI 2).** p. Provide technical assistance for the design of a pilot to improve performance of public hospitals through incentives **(IR).** q. Adjust regulations on medicine reference prices and ensure the inclusion of new classes of medicines under the regulation. In addition, define the regulatory criteria for the introduction of new contract models for high-cost medicines **(DLI 3).** r. Promote the affiliation of PEP holding migrants to the SGSSS to reduce the demand for emergency care services for late diagnosis or non-emergencies **(DLI4).**	***Efficiency***
Cross Cutting Government Program: Equity Pact for Women; women rights to live without violence			
II	***Institutional Strengthening to protect female victims of violence***		
	A. Strengthen the institutional arrangements and capacities at municipal	s. Provide TA to roll out interventions to address gender violence and supporting the implementation of the	***Quality***

Government Program: Health for all with quality and efficiency, sustainable by all	PforR	
Objectives	***Interventions and links to Results Chain***	***Results Area***
level to prevent, protect and provide care services to female victims of violence.	intersectoral mechanism to respond to gender -bases violence in pre-identified municipalities **(IR).**	

26. **The proposed PforR will be structured around two results areas[10]:**

(a) Results area 1: improve the quality of health care services; and
(b) Results area 2: improve efficiency in the health system (SGSSS)

27. **Results area 1: quality.** This results area aims to improve the quality of health care services provided by the SGSSS and to promote interventions to help the MSPS address the pressures on the delivery of care resulting from the migratory influx from Venezuela. This results area relates to Objective III (organize all health sector actors around the promotion of quality services) and Objective V (develop, strengthen and properly recognize the value of human resources for health) of the PND, and is aligned with Objective II of the Equity Pact for Women (institutional strengthening to protect female victims of violence). This results area would specifically support the following interventions to be implemented by the MSPS:

(a) Update the standards and regulations related to the certification of health care facilities. These regulatory measures will include requirements to comply with standards for climate change adaptation and mitigation, and disaster response;
(b) Update the SOGC, including the development of manuals, regulatory measures and the introduction of a mandatory, gradual accreditation process for low-complexity hospitals, and update regulations related to certification, accreditation, audit system for local quality improvement plans, and mandatory reporting of key quality of care indicators. It will also add additional dimensions to the SOGC, such as pre-service and in-service capacity building in quality of care for health workers and community engagement and participation;
(c) Develop and introduce financial incentives for quality of care for cancer patients through ex-post adjustment of the UPC payment to EPSs, including for improvement in patient-reported outcomes;
(d) Augment the capacity of health care workers in continuous quality improvement, by designing a capacity building plan for quality improvement in targeted areas such as cancer and the impacts of climate change on the health sector and health services;
(e) Develop a plan for capacity building and sensibilization of health workers in receiving areas to migrants' issues. Staff from priority departments will also be trained on protocols to ensure that qualifying migrants can exercise their health care coverage rights;
(f) Regulate the expansion of telemedicine so that better quality care can be accessed for Colombians living in rural and remote areas;
(g) Develop interoperability standards for electronic health records to improve clinical information exchange among health care professionals and achieve better care integration;

[10] The interventions under each Program's Result Area (paragraphs 27 and 28) are fully consistent with the Government program's objectives presented in Table 2. However, their logic structure is different from the table; while paragraphs 27 and 28 are sorted by Result Areas, Table 2 follows the sorted sequence of the PND objectives.

(h) Provide technical assistance to roll out interventions to address gender violence by implementing an intersectoral mechanism to respond to gender-based violence in pre-identified municipalities;
(i) Address in a timely and responsive manner the requests, complaints, claims and suggestions posted by citizens in the MSPS's website;
(j) Ensure adequacy of training for human resources for health to better meet population health needs by developing guidelines for the continuous quality improvement.

28. **Results area 2: efficiency.** This results area supports the GoC in the implementation of targeted interventions aimed at improving the efficiency in the delivery of health services, including those measures aimed at ensuring efficiency in the delivery of services to migrants. This result area relates to Objectives I, III and VI (stewardship and governance, reach efficiency in spending through the optimal use of the resources available, and the addition of new resources from all stakeholders) of the Government's program. The PforR Program will support the implementation of the following interventions aimed at achieving efficiencies in the health sector:

(a) the MSPS will develop a prioritization methodology for the benefit plan that will be submitted for consultation to citizens and scientific societies;
(b) The MSPS will foster the technical review of the risk-adjustment methodology and establish technical and institutional steering committees that will provide recommendations to adjust the UPC based on technical reports prepared by national and international experts;
(c) the MSPS will design and launch a pay-for-performance pilot in public hospitals;
(d) the MSPS will develop and approve a new methodology designed to regulate medicine prices and implement this methodology in new classes of medicines. The MSPS will also define the regulatory criteria for the introduction of high-cost drugs in the Colombian pharmaceutical market;
(e) the Program will provide technical assistance for training and capacity development to local entities in the process of registering relevant migrants and binational indigenous groups in census listings. These activities seek to promote the affiliation of migrants holding a PEP to the SGSSS and to protect the rights of these indigenous groups;
(f) the MSPS will provide technical assistance for piloting pre-judicialization mechanisms aimed at addressing cases that can be resolved outside the court system through managerial/administrative or efficiency-improving measures in order to promote citizens' right to health and reduce the inefficiencies generated by health litigation processes.

29. **The structuring of the Program's boundaries and expenditure framework, as well as the activities and results that it supports reflect the specific characteristics of the Colombian health system.** According to the Colombian legislation, the role of the MSPS is mainly of stewardship, which include the formulation and evaluation of policies, plans, programs and projects related to health insurance, provision of services, financing, pharmaceuticals, medical devices and supplies and biomedical technology and information systems, among others. In this sense, the actions, outcomes, outputs and intermediate outcomes supported by this PforR reflect the range of policy instruments available to the MSPS, which influences the insurance and service delivery functions in the system through legislation, policy and regulation rather than through direct control.

30. **Expenditure Framework.** The PND establishes an investment plan for each economic sector that it covers. The total public resources assigned for the health sector objectives amount to COP 119 trillion (approximately USD 35 billion) for the period 2019 – 2022, organized in five budgetary programs that involve current expenditures and investments. The total amount of the Program is USD 1.983 billion, of which IBRD financing is USD 150 million and USD 37.6 million is from the Global Concessional Financing Facility (GCFF), as shown in Table 3. Although marginal from a monetary perspective, WBG financing will be linked to the achievement of results that will ensure that priority is given to key sector goals and that key Government objectives articulated in the PND are met. The expenditure framework for the PforR would finance only marginally current expenditures under the SGSSS' health insurance (*aseguramiento en salud*) budget line related to the subsidized regime for three years, 2020 to 2022, to cover a portion of the expenditures related with the management of the subsidized insurance regime and a portion of personnel salaries to implement the proposed interventions[11]. The Government amount associated with these expenditures is estimated at 10 percent of the total amount assigned to the subsidized regime, which is consistent with the provision established under Law 1438 of 2011 that defines 10 percent as the maximum proportion of the UPC that EPSs could assign to administrative expenditures (which corresponds to USD 1,955 million; 99 percent of the expenditure framework). In addition, the PforR expenditure framework would include a portion of personnel salaries needed to implement the proposed interventions. The Government amount associated with this expenditure is estimated at 50 percent of the total amount assigned to MSPS's salaries from 2020 to 2022 (which corresponds to USD 28 million; 1 percent of the expenditure framework). Personnel salaries were apportioned proportionally to the amount allocated to the subsidized insurance regime from the total amount assigned to the Government's health sector program objectives (See Table A3-1, Annex 3).

31. **The funding for the program is adequate and sustainable (as it will have a positive fiscal impact) and aligned with the intended results under the Program's Result Framework.** The program has been analyzed and has been found to be fully budgeted and executed over the years, since it pays for the UPC of those affiliated to the SGSSS and the MSPS has the constitutional mandate of financing the enrollment of the poor in the SGSSS to protect their right to health, which is recognized as a fundamental right. Furthermore, Colombia's levels of health spending are not high (approximately 13 percent of total Government expenditure), particularly when compared with the OECD average of 24 percent. The fiscal impact of the operation is expected to be positive, as a poor-quality health system is technically and allocative inefficient, thus generating waste. The need for corrective services, ineffective care and avoidable hospital admissions are major sources of inefficiency. For example: avoidable hospitalization represented almost 22 percent of all hospitals discharges in Colombia in 2009. In addition, the impact of the risk adjustments to the UPC to be supported by this operation, could represent almost 0.2 percent of GDP in savings per year and some of these savings could occur in the short term.

[11] These expenditures refer to: i) transfers linked to a predetermined UPC, multiplied by the insured population duly documented in the BDUA, and ii) personnel salaries. Consequently, no procurable items, technical assistant or consultancies were identified.

Table 3. Program Financing (USD million)

Source	Amount	Percent of Total
Government	1,795.4	90.0 percent
IBRD/IDA	150.0	8.0 percent
GCFF	37.6	2.0 percent
Total Program Financing	**1,983.0**	**100.0 percent**

Box 5. The Global Concessional Financing Facility (GCFF)

The GCFF is a partnership sponsored by the WBG, the United Nations (UN), and the Islamic Development Bank Group (IsDB) to mobilize the international community to address the financing needs of middle-income countries hosting large numbers of refugees. By combining donor contributions with multilateral bank loans, the GCFF enables eligible middle-income countries that are facing refugee crises to borrow at below-regular multilateral development bank rates for providing global public goods. The GCFF represents a coordinated response by the international community to migration crises, bridging the gap between humanitarian and development assistance and enhancing the coordination between the UN, donors, multilateral development banks, and benefitting (host) countries. The GCFF includes Jordan, Lebanon, Colombia, and Ecuador as benefitting countries. The GCFF is currently supported by Canada, Denmark, the European Commission, Germany, Japan, Netherlands, Norway, Sweden, the United Kingdom, and the United States.

C. Program Development Objective(s) (PDO) and PDO Level Results Indicators

32. The Development Objective of the Program is to support improvements in the quality of health care services and in the efficiency of the health system.

33. The higher-level objective of the Program is to contribute to the longer-term goals of strengthening the financial sustainability of the health system and improving health outcomes.

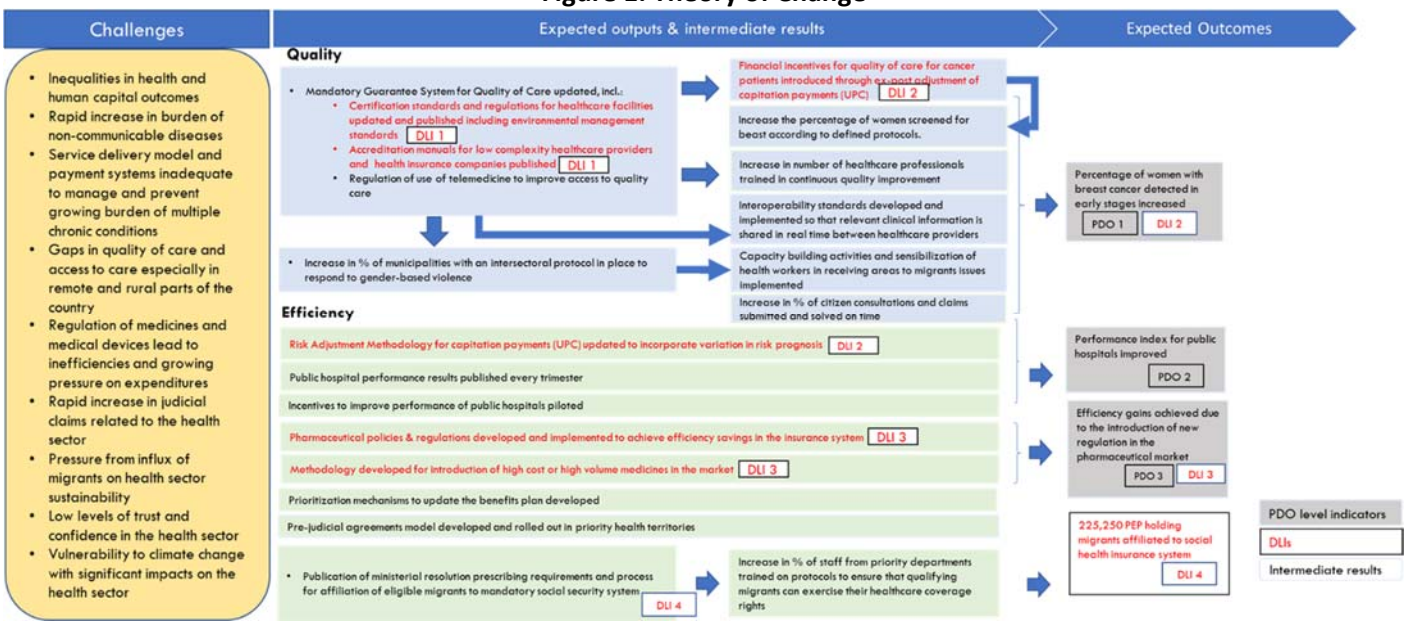
34. **Three PDO indicators have been selected to measure progress in achieving the two results areas of the Program.** The three PDO indicators proposed are also indicators of the PND endorsed by the Colombian Congress, for which the Government has committed the achievement of specific results by the end of calendar year 2022:

(a) Percentage of women with breast cancer detected in early stages, up to stage IIA, at the time of diagnosis;
(b) Performance index for public hospitals (composite performance index of 17 performance indicators); and
(c) Efficiency gains achieved over the period 2020-2022 with the introduction of new regulations in the pharmaceutical market.

35. **The proposed Program aims to achieve its PDO by addressing institutional constraints that hinder quality of care in service delivery and efficiency in the SGSSS.** Quality and efficiency are intrinsically related – a poor-quality health system is technically and allocatively inefficient – and both contribute to the health system's long-term financial sustainability. As noted above, low-quality care implies ineffective and avoidable care and the need for corrective services, all major sources of

inefficiency. In addition, low-quality of care also has an obvious negative impact on health outcomes: t is estimated that in Colombia, 65 percent of all deaths attributable to the health care system are due to poor quality of care. Theories of change for each Results Area are presented in Figure 1 below. The results chain depicted in Figure 1 is fully consistent with the Government priorities that were presented in Table 2. However, in order to show the sequential linkages and synergies between different interventions that will be implemented and the expected results, its logic structure is different from the table, which follows the sorted sequence of the PND objectives.

Figure 1. Theory of Change



D. Disbursement Linked Indicators and Verification Protocols

Results Area 1: Quality of Care

36. **DLI 1.** Updated and new regulations defining the processes and standards for the certification (*habilitación*) and accreditation of IPSs and for the accreditation of the EPSs, that include environmental management standards and disaster readiness.

37. **Rationale.** The recent assessment of quality of care in the public and private health sectors carried out by the WBG and the IFC ("External Assessment of Quality of Care in the Health Sector in Colombia," 2019) analyzed the state of quality of care in Colombia and the capacity of the sector to improve quality of care. The study identified large gaps in quality of care in the sector and recommended that to improve quality of care, actions should be taken to: (a) strengthen capacity for continuous quality improvement in the health sector; (b) strengthen the quality ecosystem in the sector; (c) improve the rigor and use of information on quality to stimulate patient choice and peer learning for IPSs; (d) develop and implement an integrated care model to support the management of individuals with complex, chronic health care needs; and (e) improve accountability and contracting mechanisms to incentivize for quality. DLI1 addresses specifically the second recommendation, of the study, which focuses on strengthening the

quality ecosystem in the sector. DLI1 will incorporate the approval of the new resolution for certification of IPSs, including new requirements to comply with standards for climate change adaptation and disaster response, to prevent or reduce the effects of climate change on health facilities. These adaptation guidelines and standards will include specific measures to ensure facilities are able to deal with extreme heat events through effective insulation and shading, and that they are equipped to respond to wildfires with axes, fire beaters, as well as having ambulatory facilities able to deal with these threats.

38. **Description.** The Government will seek to achieve three specific results related to this DLI that will be documented by the following triggers: (a) the publication in the official journal of the Republic of Colombia a new regulation updating certification standards to be met by health care facilities that will include standards for environmental management; (b) the publication in the official journal of the Republic of Colombia a regulation introducing a new accreditation process for EPSs that will define quality standards and processes to ensure that standards are met by the EPSs; and (c) the publication in the official journal of the Republic of Colombia a regulation defining quality standards and simplified processes for the accreditation of low-complexity hospitals. DLI1 will support the approval of new parameters for IPSs and EPSs accreditation, including new requirements for construction, infrastructure, environmental and energy saving, among others. For example, where necessary, facilities will be renovated or even relocated to reduce flood risk, either from sea level rise in coastal areas or from flash and/or river flooding in inland and mountainous areas. In addition, the guidelines and procedures established for energy saving are based on insulation systems, lighting, refrigeration, and provision of adequate equipment, among others, and are enhanced with the objectives of efficiency and quality of health services. Examples of the guidelines include: (a) energy efficiency improvements in lighting, appliances and equipment, including energy-management systems, (b) energy efficiency improvements in public services, through the installation of more efficient lighting, (c) energy efficiency in new buildings using highly efficient architectural designs, energy-efficient appliances and equipment, and building techniques that reduce the energy consumption, and (d) energy audits of energy end-users.

39. The National Planning Department *(Departamento Nacional de Planeación,* DNP) will be responsible for the verification of the publication of the three regulations in the official journal of the Republic of Colombia. The Government may need technical assistance to ensure that the DLIs are met accordingly with the time requirements proposed in Annex 2.

40. **DLI 2.** Incentives in the payment system to achieve higher quality of care and efficiency.

41. **Rationale.** The fifth recommendation of the quality assessment of the health sector in Colombia proposes *inter alia* that payment and contracting mechanisms between the MSPS providers and insurers should be strengthened. Examples include incentives to prevent patients from developing high-cost conditions such as renal failure, through prevention and good chronic disease management or ex-post risk adjustment mechanisms for high cost patients or targeted groups of patients such as cancer patients, using the mechanism for high cost patients accounts. This can be achieved through the introduction of an ex-post adjustment to UPC incentivizing EPSs for better quality and efficiency in health care service delivery; and through an update of the risk-adjustment methodology for UPC, which would better incorporate variation in risk prognosis. Conceptually, the UPC should compensate fairly the costs incurred by insurers from the provision of health services included in the health benefits package (*Plan de Beneficios en Salud*, PBS). Not all users have the same health risks, and typically higher risk equals higher

utilization of services and higher costs. Health risk often correlates with variables such as age, geography, gender, socioeconomic status, preconditions, lifestyle, etc. To balance those risks across populations (low risks subsidizing high risks), a process called risk adjustment should be applied in the design of the UPC. Currently, a basic risk adjustment is utilized by the MSPS, which includes only variables such as gender, age group and place of residence. This adjustment is suboptimal and can be improved, considering new information available for the sector and novel techniques of data analysis. An improved risk adjustment methodology has the potential to increase efficiency in the utilization of the resources and contribute to the financial sustainability of the system. Additional interventions to achieve this result could include supply-side and demand-side interventions such as the launch of a national quality campaign to improve early detection of breast cancer; and outreach campaigns to target populations to raise awareness among women about the importance of accessing regular screening services and engaging in self-examination.

42. **Description.** Through DLI2 the PforR seeks to promote: (a) the introduction of ex-post financial incentives for EPSs to achieve higher standards of access and quality of care including earlier screening of breast cancer, as specified in the PND; and (b) the updating of the risk adjustment methodology of the UPC. DLI2 focuses specifically on early detection of breast cancer, which has a higher incidence rate and for which early detection and treatment leads to relatively high survival rates over time.[12] In this sense, a new regulation describing the financial incentives that will be attached (ex post) to the payment of UPC for EPSs that better perform in early detection of cancer, will be published in the official journal of the Republic of Colombia in 2020. This result will be verified by the DNP. A target of 69 percent of breast cancers detected by stage 2A is proposed as a result to be achieved by end of calendar year 2022, as defined in the PND. Results for this DLI are to be verified by the DNP. A nominal clinical registry is implemented and regularly audited (*cuenta de alto costo, CAC*) and will be used by the DNP and the MSPS to monitor results over time. Further details are presented in Annex 2. The Government may need technical assistance to ensure that results for DLI2 are met in accordance with the time requirements proposed in Annex 2, especially regarding better outcomes measurement and possibly the introduction of patient-reported outcomes measurement for cancer patients. In addition to these quality-related targets, DLI2 also seeks to promote changes to the risk adjustment methodology of the UPC, to better reflect efficiency goals of the system. This adjustment to the UPC must consider not only technical criteria, but also institutional elements imposed by implementation challenges. In order to achieve these results, DLI2 defines the following triggers: (a) the risk adjustment methodology of the UPC, dully discussed and resulting technical document published on the MSPS website; (b) the resolution defining the ex-post adjustment of the UPC rewarding early cancer detection published in the official journal of the Republic of Colombia; and c) at time of dignosis, at least 69 percent of women with breast cancer detected were at stage IIA or earlier.

[12] The evolution of breast cancer is identified through five broader stages (from stage 0 to stage IV) that are further subdivided. Stage II breast cancer indicates a slightly more advanced form of the disease. At this stage, the cancer cells have spread beyond the original location and into the surrounding breast tissue, and the tumor is larger than in stage I. However, stage II means the cancer has not spread to a distant part of the body. In stage IIA one of the following is true: a) here is no tumor within the breast, but cancer has spread to the axillary (underarm) lymph nodes; b) the tumor in the breast is 2 cm or smaller and cancer has spread to the axillary lymph nodes; or c) the tumor in the breast measures 2 cm to 5 cm but cancer has not spread to the axillary lymph nodes.

Results Area 2: Efficiency

43. **DLI3.** Efficiency gains in pharmaceutical expenditure as a consequence of pharmaceutical market regulatory policies.

44. **Rationale.** As described earlier, the cost of medicines represented, on average, approximately 21 percent of the SGSSS total health spending between 2007 and 2017, but until the early 2010s Colombia did not have a framework to regulate pharmaceutical prices. Since then, the MSPS has introduced several measures to improve and strengthen its pharmaceutical policies. However, results in terms of access to medicines and total spending have been mixed and the country still needs to further develop its capacity to supervise and monitor pharmaceutical services. The reimbursement, through judicial claims, of high-cost inputs (mostly medications), services and procedures not included in the benefit plan (No PBS) have escalated in the past 10 years, from COP 600 billion in 2007 to COP 2.5 trillion in 2016, i.e. around 10 percent of total expenditure of the MSPS.

45. **Description.** This indicator consists of the introduction and implementation of new methodologies for price regulation of medicines and for the introduction of high cost drugs in the market, and the analysis of the pharmaceutical market in order to define which medicines should be incorporated into the probation regime (*regimen de libertad vigilada*), to achieve efficiency gains in the insurance system and allow better access and coverage of medicines. Four actions will be undertaken by the MSPS to achieve total savings of COP 800 billion: (a) publication for public consultation of the administrative act that defines the methodology for the regulation of prices of medicines; (b) application of the existing price regulation methodology to at least 50 relevant markets; (c) publication in the official journal of the Republic of Colombia of a regulation (c*ircular*) defining the methodology used to control the introduction of high cost drugs in the market (regulation of the *puerta de entrada*) ; and (d) the regulatory measures implemented by the MSPS lead to efficiency gains, measured by the difference between the regulated price and the original price (as reported in the Drug Price Information System *(Sistema de Información de Precios de Medicamentos,* SISMED), that sum at least COP 800 billion.

46. **DLI4.** Number of eligible migrants affiliated to health insurance scheme.

47. **Rationale.** Venezuela is currently going through the worst economic and social crisis in its recent history. Falling GDP, universalization of poverty, hyperinflation and depreciation of the local currency have all accelerated in the last five years, leading to massive emigration of Venezuelans. Shortages of food and basic medicines have pushed nearly three million Venezuelans out of their country. A large share (approximately 1.63 million as of October 31, 2019), of these migrants is currently in Colombia. As discussed in Box 1, the impact of the migratory phenomenon on the health system of host communities, particularly in the already underserved frontier departments, has been significant, as the utilization of health services by Venezuelan migrants has increased exponentially between 2017 and 2019, since Venezuelan migrants tend to be poor and highly vulnerable Furthermore, most of these migrants are not insured so can only receive emergency care free of charge at the point of provision. There are several reasons why affiliation of migrants should be increased, starting with regular migrants: (a) ensuring that there are enough resources available to finance the provision of emergency services to migrant population and avoid the collapse of public facilities providing these services, which would also negatively affect the host population; (b) improving the quality of service provision and better adapting them to the needs of the migrant population through increasing capacity and sensibilization of health personnel and ensuring

the provision of migrant focused services; (c) increasing efficiency by increasing the pools of risk and resources, by ensuring that all eligible migrants affiliate to the mandatory social security system; (d) increasing the number of people affiliated will likely increased access to PHC services, including screening and diagnostic services, since they will be pre-paid and often subsidized; decreasing therefore the likelihood of complication and the use of already overburden emergency services; (e) preventing/stopping the transmission of vaccine preventable diseases; and (f) ensuring better organization of service delivery so that negative impacts on host populations are reduced and migrants are better accepted by host populations.

48. **Description.** The indicator consists of the affiliation to the mandatory social security system of new migrants from Venezuela who are regularly registered and provided with a renewable PEP. The affiliation to the mandatory social security system will give migrants the same rights as any other Colombian citizen. A prior action will consist of the publication in the official journal of the Colombian Republic of a ministerial resolution defining the conditions under which migrants are eligible to access health care services in Colombia and processes to be enrolled in the SGSSS. The final result to be achieved consists of having a total of 425,000 PEP holder migrants from Venezuela enrolled in the mandatory social security system: 225,250 financed by the WBG and 199,750 by the IDB. The triggers for WBG disbursement are: 139,500 migrants affiliated in year 1; 197,000 in year 2 and 225,250 in year 3.

49. **The DNP will be the agency responsible for the verification of Disbursement-Linked Indicators results**, as it has the legal responsibility for monitoring the performance of the indicators defined in the PND (see Implementation Arrangement Section). Verification will rely on existing information systems – Government databases where reporting and data quality are confirmed as meeting high standards of quality. Verification processes will involve confirming changes in regulatory documents, reviewing system reports from established databases, and conducting sample checks. The verification protocol for the DLIs (both verification entity and verification process) is described in Annex 2 and included in detail in the Program's Operational Manual (POM).

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

50. **The Program will be implemented by the MSPS which will provide overall oversight of Program execution.** The MSPS will be responsible for high level coordination with the other actors involved in Program implementation. The role of these other institutions is described below. As noted earlier, the MSPS is responsible for overall stewardship of the health system; as such, it develops norms, standards and guidelines required by EPSs and IPSs and provides technical assistance for their implementation. The MSPS also regulates quality standards and the accreditation system for EPSs and IPSs. The MSPS establishes the requirements for EPSs to purchase, contract and monitor the provision of health care services. (More details on roles and responsibilities among the participant entities are provided in Annex 3).

51. **The National Direction of Health Sector Financing (*Dirección de Financiamiento Sectorial*, DFS) within the MSPS will be the technical and operational coordination unit for the Program.** DFS will be responsible for coordinating the Program activities through the Ministry's different departments, such as

Quality, Regulation, Insurance, Health Promotion, Service Delivery, Environmental Health, Human Resources, among others. The DFS will be responsible for: coordinating the collection of data to monitor indicator performance and reporting of DLIs; coordinating the external verification with the DNP; reporting on the financial statements; and finally, for submitting the disbursement requests to the Ministry of Finance *(Ministerio de Hacienda y Crédito Público,* MHCP). Within the MSPS, Program-relevant departments, as well as in each of the other participating entities, a team of one or two key staff members will be designated as focal points. They will be responsible for supervising Program implementation according to their areas of competence and ensuring timely coordination to achieve the DLI targets. They will work in close collaboration with DFS. DFS is staffed with a National Director who will be the Program Coordinator, and with technical staff members who have the adequate capacity to support the Program implementation.

52. **The Administrator of the Resources of the General System of Social Security in Health *(Administradora de los Recursos del Sistema General de Seguridad Social en Salud,* ADRES)**,[13] is responsible for the administration of the health system resources and payments, according to the information provided by the consolidated database of people enrolled in the SGSSS, BDUA, managed by the MSPS. In this sense, Program funds will be transferred to ADRES through the monthly UPCs, which finance the operation of the POS system.

53. **The National Health Superintendence (*Superintendencia Nacional de Salud*, SNS)** is the authority responsible for carrying out the inspection, surveillance and control of the constitutional and legal norms of the health sector and its resources. In this sense, as part of its institutional mandate – the SNS is responsible for the inspection, surveillance and control of the constitutional and legal norms of the health sector and its resources – the SNS ensures the appropriate use of health resources and that the public and private actors subject to its surveillance are fulfilling their obligations, but the SNS is not directly involved in the delivery of the Program's interventions.

54. **The EPSs are responsible for the provision of the health insurance schemes to the population.** The EPSs receive the UPC, times the number of persons that it insures, from ADRES. As mentioned before, the EPSs compete for consumers in terms of the quality of the services offered, since they cannot compete on price.

55. **The Comptroller General of the Republic (*Contraloría General de la República*, CGR)**, is responsible for conducting annual financial audits of the MSPS; as well as of ADRES; covering the Program transfers made by the MSPS to ADRES and the BDUA.

56. **The DNP** has the legal responsibility for monitoring the performance of the indicators defined in the PND. As the Program results framework indicators and DLIs are aligned with those in the PND, the DNP will be the independent agency responsible for conducting the external verification and reporting of DLIs compliance, in accordance with the verification protocols agreed with the MSPS and reflected in the OM. The DNP is an Administrative Department reporting directly to the Presidency of the Republic; as part of its functions, the DNP is responsible for planning, evaluating and coordinating the actions required for

[13] ADRES is a decentralized organization associated to the MSPS, but with administrative and financial autonomy and independent assets. ADRES operates in a similar way to a private institution. Its legal framework is established in article 66 of Law 1753 of 2015.

the implementation and development of the National System of Evaluation of Management and Results (SYNERGY). DNP is also responsible for the evaluation of public policies and for strengthening results-oriented management at national and territorial level. In this sense, it must develop and implement mechanisms for monitoring and evaluating the impacts of programs and projects executed by national and territorial Government institutions.

B. Results Monitoring and Evaluation

57. **The monitoring and evaluation data provided by internal and public sources are largely reliable**. The progress of indicators related to regulatory changes will be verified in the *Diario Oficial*, as the official journal of the Republic of Colombia that publishes legal acts and public notices of the President, Congress, and Government agencies. Data for quantitative indicators will be provided by databases contained in the Social Protection Integrated Information System (*Sistema Integrado de Información de la Protección Social*, SISPRO), a data warehouse that contains homogenized registries from comprehensive databases on topics related to health and social services for most of the population. Qualitative indicators will be monitored according to the verification of milestones and processes described in the verification protocol (Annex 2).

58. **The DFS of the MSPS will oversee program implementation progress**. The DFS will be responsible for collecting the information required to ensure DLI compliance and for submitting it to the independent verification agency, as well as for submitting the disbursement requests based on DLI achievement. Likewise, the DFS will ensure that technical and analytical areas of the MSPS report timely progress of program indicators (DLIs and PDOs). The DFS will serve as the focal point to the WBG for the purposes of program supervision and will submit progress reports as required. The WBG will provide analytical, administrative and technical support to the DFS, based on the Implementation Support Plan (Annex 7).

C. Disbursement Arrangements

59. **The Program funding will be based on the achievement of DLI targets as certified in accordance with the independent verification protocol**, the disbursement arrangements will be as follows:

(a) Program funds will flow from the WBG Loan Account to the MHCP USD-nominated foreign account at the Central Bank of Colombia or in a commercial Bank accepted by the WBG, upon the achievement and verification of DLI targets to the WBG's satisfaction. Disbursement requests to the WBG will be made by MSPS, according to the agreed disbursement schedule;

(b) Funds in this account will be managed through the national Integrated Financial Information System (*Sistema Integrado de Información Financiera*, SIIF), an automated system that coordinates, integrates, centralizes and standardizes the national public financial management to promote greater efficiency and security in the use of the resources of the national general budget (*Presupuesto General de la Nación*, PGN). Funds will be transferred in COP, at the request of the MSPS, to ADRES and will be reflected in the budgetary execution of these two entities[14];

[14] Before transferring to ADRES, the funds will be re-allocated from domestic funding to external financing.

(c) Loan funds are budgeted under the MSPS's subprogram "insurance and management of the SGSSS" and budget line *aseguramiento en salud* (health insurance), which is a current expenditure related to the subsidized regime, as well as under the MSPS salaries budget line.
(d) The MSPS will not request advances of funds from the Loan;
(e) Up to 25 percent of the IBRD loan amount (USD 37.5 million) may be withdrawn based on verification that agreed DLIs have been achieved prior to the signing of the Legal Agreement;
(f) The time frame for achieving each Disbursement Linked Result (DLR) considers the government's need for budget predictability and flow of funds. There is no restriction on early achievement of the DLRs; payment will be disbursed as and when targets are achieved and verified. DLIs that are scalable have been identified and no period limitation for achievement apply. However, DLR's achievement assessment will be done on a calendar year basis (ending September 1), with verification of results done within two months after that deadline. Disbursements for the assessment year is expected to be done by September 30.

D. Capacity Building

60. **The Program will be implemented using existing institutions and arrangements.** The MSPS will provide overall oversight to the Program, facilitate strategic decision making and ensure cross-agency coordination during Program implementation. Although the financial support provided by this operation will be small, relative to the size of Government spending, and no institutional changes are expected, the Program is the construct of a valued analytical and advisory engagement that the WBG has established with the Colombian health authorities in the past four years and different Government administrations. This indicates that a continued support should be maintained throughout the Program. In addition, the Program will be the first PforR operation in any sector in Colombia and, as such, there is a strong interest by the MSPS and the MHCP in using the development and implementation of this operation as a learning opportunity for the country and as a model for other sectors.

61. **As part of the technical assessment, the following topics have been identified for capacity building and institutional strengthening under each of the results areas.**

(a) **Quality**: Technical Assistance (TA) to update the SOGC; TA for increasing the capacity of health sector workers in continuous quality improvement; TA in conducting an in-depth assessment of the performance of its PHC system in partnership with the PHCPI and using its framework and core indicators;
(b) **Efficiency:** TA for reviewing the risk-adjustment methodology and to propose recommendations for adjustments to the UPC; TA for pharmaceutical markets regulation; TA for designing pay for performance pilots at the hospital levels; TA for the technical assistance in issues related to the judicialization of health (through the WBG's *SaluDerecho* platform); capacity building for developing interoperability standards and health data analysis;
(c) **Quality and Efficiency for migrants and indigenous population:** Capacity building and sensibilization of health workers in receiving areas on issues related to migrants' health, and training on migrants' protocols and guidelines to ensure that qualifying migrants can exercise their health care coverage rights. In addition, the GoC is committed to ensuring that the rights and dignity of LGBTQ2 migrants are protected, including access to critical health services. The WBG will provide technical assistance on best practices and new tools (including digital technology) to enhance access to critical preventive, diagnostic and curative services that

LGBTQ2 persons among Venezuelan migrants need to manage risks and burden of disease of HIV/AIDS, mental health, and other diseases;

(d) **DLI reporting and verification:** Capacity building in the process of collecting the data for reporting the DLIs, and for the DNP to strengthen the verification process of compliance with the DLIs, among others to be included in the Program Action Plan (PAP).

62. **The MSPS will receive technical assistance from the PHCPI.** Through this partnership, the MSPS will receive technical assistance to carry out a detailed performance assessment of its PHC system at national and sub-national levels and will engage with other participating countries and technical and institutional partners to consider interventions and policies leading to higher performing PHC delivery models and monitor results over time.

63. **As part of the fiduciary assessment, the following areas have been mainly identified for capacity building and institutional strengthening:** capacity enhancement support to the CGR, to effectively audit program activities at the MSPS and at ADRES; capacity building for the MSPS to enhance the financial reporting of program activities.

64. **Implementation support will be provided for all necessary external TA and other key capacity building activities through a combination of different sources.** First, through the implementation support budget; second through the WBG initiatives already mentioned such as PHCPI and *SaluDerecho*; third, with the use of WBG-managed trust fund resources such as Access Accelerated in the area of pharmaceuticals; and finally through the use of Externally Financed Outputs (EFO), such as the one that is being developed with UnitedHealth Group for the methodological assessment and revision of the UPC; resources from the State and Peacebuilding Fund (SPF) are supporting TA for training and other capacity development efforts to strengthen the sector's ability to address some of the challenges related to the Venezuelan migration. Depending on the nature of the task, capacity-building activities can take the form of just-in-time TA, knowledge and experience exchange with other countries, or long-term advisory support.

IV. ASSESSMENT SUMMARY

A. Technical (including program economic evaluation)

Strategic relevance

65. **Strategic relevance.** The SGSSS provides almost universal insurance coverage and a significant level of financial protection to its beneficiaries and is regarded as one of the country's major social achievements of the last decades. However, much of the focus of the Colombian health policy since the health reform of 1993 has been directed towards the expansion of insurance and service provision coverage. This model boosted the provision of curative care to the detriment of health risk management and health promotion and primary and secondary prevention. As a result, efficiency and quality indicators remain below optimum levels and have led to lower than desirable progress in health outcomes. In this sense, the Program's development objective of improving quality and efficiency in the delivery of health care services and, therefore, contributing to strengthening the financial sustainability of the Colombian health system and improving health outcomes, responds to the challenges described above. This goal is

also directly aligned with the health sector goals of the country's PND for the 2018-2022 period. In fact, the objectives of this PforR mirror the title of the Government's health sector program that it supports: "Health for all with quality and efficiency, sustainable by all." Furthermore, the Program goals and the strategic vision of the MSPS contain five areas: (a) long-term perspective; (b) quality; (c) public health; (d) human resources for health; and (e) financial sustainability. Finally, the Program also responds to the difficult economic and social context generated by the oil shock of 2015-2016 that was exacerbated by the commitments of the peace process and the massive migration from Venezuela, as quality and efficiency-enhancing measures will be necessary for the health sector to adjust to the additional fiscal consolidation measures that will have to come over the 2020-2022 period.

66. **Technical and financial soundness.** The Program is the direct result of the analytical and advisory engagement that the WBG has established with the Colombian health authorities in the past four years. The work developed by the WBG supported analytical and advisory activities related to the efficiency and financial sustainability of the system, such as: the Atlas of Geographic Variations in Health; the support to increase tobacco taxes; the study of multi-morbidities; the assessment of the impact of migration in Colombia and response strategies; the technical assistance to strengthen the governance and financial management of the health system; the technical assistance in issues related to the judicialization of health; and the three-phase RAS to support the SNS in the development of a risk-based supervision model. The Program is also informed by a baseline assessment of health care quality in public and private service delivery in Colombia developed by the WBG, as well as by an in-depth assessment of the performance of its PHC system using the PHCPI framework. It is important to note that quality and efficiency are intrinsically related, and both contribute to the health system's long-term financial sustainability. First, because low-quality of care can be costly in terms of human suffering and loss. Poor quality of care causes 10 to 15 percent of total deaths in low- and middle-income countries and generates waste. A poor-quality health system is technically and allocatively inefficient. The need for corrective services, ineffective care and avoidable hospital admissions, for example, are major sources of inefficiency.

67. **The funding for the Program is adequate, sustainable (as it will have a positive fiscal impact) and aligned with the intended results under the Program's Result Framework**. The activities and expenditures under the Program will be funded from the budget assigned by the MHCP to the MSPS. This budget has been analyzed and has been found to be fully budgeted and executed over the years, since it pays for the UPC of those affiliated to the SGSSS. Colombia's levels of health spending are not high, particularly when compared with the OECD and Government health spending has not grown as fast and, in fact, has essentially leveled-off after 2008. Furthermore, the share of total government health spending as a proportion of total government expenditure is significantly smaller than the OECD average and even below the Abuja targets set for Sub-Saharan Africa and the MSPS is constitutionally mandated to pay for those affiliated to the subsidized regime. The fiscal impact of the operation is expected to be positive and will largely occur in the longer-term. The impact of the risk adjustments to the UPC to be supported by this operation, could represent almost 0.2 percent of GDP in savings per year and some of these savings could occur in the short term.

Economic evaluation

68. **The economic analysis of the Program was conducted using a cost-benefit analysis (CBA) to determine if the economic rationale for the Project is sound.** The benefits and costs accounted for in this project were modeled using a macro-fiscal, systemic and demographic scenario. The proposed framework

projects a scenario of the Colombian context for a period of 12 years, from 2019-2030, although the benefits and costs are computed for the length of the project (3 years). For the CBA, two general types of benefits were applied. The first one is the reduction of the burden of disease, expressed as Disability Adjusted Life-Years (DALYs) in relevant interventions associated with DLI 1 and the third DLR of DLI 2 (breast cancer screening). The second type of economic benefit accounted for is monetary, through expected reduction in total costs through interventions associated with the second DLR of DLI 2, DLI 3 and DLI 4. A sensitivity analysis was conducted to increase the confidence range by estimating the variability of key assumptions, such as the discount rate, burden of disease reduction and the direct effect of interventions on costs.

69. **The results of the analysis indicate that the Program is highly cost-beneficial.** The base scenario estimates provide a net present value (NPV) of USD 213 million and a reduction of approximately 16,034 DALYs. The sensitivity analysis shows positive returns even in a scenario where very small impacts are modeled. This result can be explained by the relatively low amount of investment required to generate significant effects in a system like Colombia's. The details of the model and key assumptions can be found in Annex 3.

Table 4: Cost-Benefit Analysis Results

Concept	Scenario		
	Base	Low	High
NPV Costs (USD million)	170.2	164.4	176.4
NPV Benefits (USD million)	383.2	273.2	552.5
NET BENEFIT (USD million)	213.0	108.8	376.1
BENEFIT COST RATIO	2.3	1.7	3.1
TOTAL DALYs SAVED	16,034	9,964	20,155

B. Fiduciary

70. **The Program fiduciary systems are adequate and provide overall reasonable assurance that the Program financing proceeds will be used for the intended purposes, nevertheless, the environment of the Program fiduciary systems still presents some vulnerabilities that are being addressed by the GoC**. The Fiduciary Systems Assessment (FSA) has been conducted by the WBG to review the capacity of the implementing entities on their ability to: (a) record, control, and manage the Program resources and produce timely, understandable, relevant, and reliable information for the borrower and the WBG; and (b) ensure that implementation arrangements are adequate, and risks related to financial management, fraud and corruption, as well as the complaints handling mechanisms, are reasonably mitigated by the existing framework. The FSA preliminary conclusions are reflected in Annex 4.

71. **The assessment found that the implementing entities, MSPS and ADRES, have adequate institutional capacity to manage the Program; however, the systems and processes could be strengthened in the following areas**: (a) financial accounting and reporting; due to the large number of income sources that are part of the SGSSS, the complexity of the processes for insurance payments, and the high volume of transactions; (b) payment processes, including the cleaning of the BDUA, and updating the risk-adjustment methodology that defines the values of the UPC; and (c) the periodic reconciliation of accounts. The MSPS and ADRES are addressing these concerns, and other challenges mainly toward the

implementation of the end point agreement (*Acuerdo de Punto Final*) stated in the law 1955 of May 25, 2019 of the PND[15].

72. **Audits of financial statements of the Program. The 2018 and 2019 financial and special audits carried out by the CGR,** related to the Program, included findings that the implementing entities are taking into consideration in compliance with the improvement plans presented to the CGR. As a mitigation measure for the Program, capacity enhancement activities will be included in the PAP to support the CGR to effectively audit program activities at the MSPS and at ADRES during the financing period.

73. **Procurement.** As referred in Section C (Program expenditure framework) of Annex 3 of this PAD, the Program will support: (a) transfers to marginally finance a portion of current expenditures under SGSSS' health insurance (*aseguramiento en salud*) budget line, from the MHCP to ADRES. These transfers consist in a predetermined UPC, multiplied by the insured population duly documented in the BDUA; and (b) personnel salaries to implement the proposed interventions. Consequently, no procurable items were identified within the Program expenditure framework and no specific Procurement arrangements are needed.

74. **The Program will depend on the Government's framework for prevention and control of fraud and corruption.** In Colombia, there are extensive legislation and regulations aimed at fighting corruption. Corruption risk management is mandatory for all public entities since 2011, under the Anti-Corruption Statute established in Law 1474. In compliance with the WBG's Anti-Corruption Guidelines, the CGR will provide to the Bank information on allegations of fraud and corruption, handling of said allegations, and final findings, all related to the Program and covering the MSPS, ADRES and EPS.

75. **A robust complaint–handling mechanism is in place**. The law states that any citizen can make their petition, complaint, claim, or suggestion through the Mechanism for Petitions, Complaints, Claims, and Suggestions (*Petición, Queja, Reclamo, Sugerencia o Denuncia,* PQRSD), including complaints related to fraud and corruption. It is under the responsibility of Internal Control offices, to monitor and evaluate the management of the PQRSD related to the MSPS and the ADRES in the framework of the opportunity transparency efficiency and effectiveness. (see paragraph on Citizen Engagement below). The PAP requires reporting to the WBG any information on Fraud and Corruption, and complaints handling coming from officially sources.

C. Environmental and Social

76. **The Environmental and Social Systems Assessment (ESSA) for this Program was undertaken to**: (a) identify the possible benefits, risks and environmental and social impacts applicable to the interventions of the Program; (b) review the policy and legal framework related to the management of the environmental and social impacts of Program interventions; (c) assess the institutional capability regarding environmental and social management systems within the Program system; (d) assess the performance of the Program system with respect to the basic principles of the PforR instrument and identify gaps, if any; and (e) submit recommendations and PAPs to address gaps and improve performance during the program's implementation.

[15] Including the implementation of strategies to optimize the information systems to maintain the BDUA; the reconciliation of accounts based on transparency; increasing the qualified staffing; and improving the effective technical audits; among others.

77. **The combined risk assessed at entry is low; the ESSA confirms that the current system for managing the environmental aspects of the Program are reasonably covered by the regulations and institutional capacity of the entities involved**, where the MSPS establishes the policies and the decentralized authorities carrying out actions of inspection, oversight and sanitary control. The findings from the ESSA are intended to ensure that the Program is implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes or mitigates adverse environmental and social impacts and risks. The PAP includes activities that would bridge the remaining gap in the environmental and social management systems in line with the PforR.

Environmental System

78. **The Program does not have explicit environmental management objectives. The ESSA confirms that the current system for managing the environmental aspects of the Program is reasonably covered by the country's regulations and institutional capabilities and is consistent with the WBG's PforR Policy and Directive.** The results areas identified under the Program and the corresponding DLIs do not recommend activities and/or actions that will have significant adverse impacts on the environment that are sensitive, diverse, or unprecedented.

79. **The program activities will not generate a significant increase in medical waste compared to the current situation. The general adequacy of the institutional and legal framework for medical waste management at the facility level was confirmed during the assessment**. The MSPS establishes the policies and the decentralized authorities carry out the actions of inspection, surveillance and sanitary control (*inspección, vigilacia y control sanitario*, IVCS). The management of health care waste (HCW) has two instances, one within the health facilities (intramural) under the monitoring of the MSPS, and another one outside the IPS (extramural), under the supervision of the Ministry of Environment and Sustainable Development (*Ministerio de Ambiente y Desarrollo Sostenible*, MADS). At the sub-national level, the departmental, district and local health authorities are responsible for the IVCS function as well as for the management of intramural HCW. At an extramural level, the external management of the HCW is under the purview of the regional environmental authorities (Regional Autonomous Corporations, Corporations for Sustainable Development and Urban Environmental Authorities) in accordance with the legal provisions and policies of the MADS. Key issues identified by the Environmental System Assessment are not connected with any further capacity building and may be addressed through the continuous enforcement of the specific regulatory framework issued by the GoC. The relevant implementation of environmental actions is defined in the PAP.

Climate Mitigation and Adaptation Measures

80. **Exposure**. As mentioned under Section I.B, Colombia is particularly vulnerable to the impacts of climate change. For the period of 1995–2005, precipitation increased from December to February by 5 percent. Trends in Colombian river stream runoff are mixed, but the main river catchments such as the Cauca and Magdalena Rivers exhibit decreasing trends (possibly resulting from deforestation). The frequency of extreme rainfall events has increased. The maximum amount of rain that falls in any 5-day period - as indicator of extreme weather - is projected to increase and the maximum period between rainy days is expected to decrease. Temperatures across Colombia are projected to increase between 1°C and 2.5°C by 2100.

81. **Climate and disaster risk screening conducted for the Program confirmed that the risk of exposure to climate change is Moderate.** Program activities could be affected by extreme precipitation and flooding, disturbing the access to facilities, damaging the health service infrastructure, and increasing the incidence of vector-borne diseases such as malaria and dengue. Recent work reported under the Integrated National Adaptation Program (INAP) points to a gradual trend in Colombia of exposure to tropical vector diseases (malaria, in particular). Approximately 23 million and 13 million Colombians live in areas of endemic dengue and malaria transmission, respectively, and about 85 percent of Colombia's territory presents suitable ecological, climate, and epidemiological characteristics for malaria transmission.

82. **Climate Adaptation and Mitigation Measures Supported by the Program.** Through its Results Areas, the Program seeks to improve the quality of health services as well as promote a more efficient system, including for uninsured populations (such as migrants). These would be critical in managing the health care delivery response to diseases exacerbated by the effects of climate change. DLI1 will incorporate the approval of the new resolution for certification of IPSs, including new requirements to comply with standards for climate change adaptation and disaster response, to prevent or reduce the effects of climate change on health facilities. These adaptation guidelines and standards will include specific measures to ensure facilities are able to deal with extreme heat events through effective insulation and shading, are equipped to respond to wildfires with axes, fire beaters as well as having ambulatory vehicles able to deal with these threats. Through DLI1, the Program will support the approval of new parameters for IPSs and EPSs accreditation, including new requirements for construction, infrastructure, environmental and energy saving, among others. For example, where necessary, facilities will be renovated or even relocated to reduce flood risk, either from sea level rise in coastal areas or from flash and/or river flooding in inland and mountainous areas.

83. **This Program will implement further adaptation solutions to the climate challenge as follows.** As indicated by the Program intermediate indicators ("Number of health care professionals trained in continuous quality improvement", and "Interoperability standards developed and implemented"), the PforR will contribute to climate adaptation as health workers will be educated on climate impacts and disaster response firstly by including climate adaptation topics in medical and nursing school curricula (as well as other trainings for health care professionals) and secondly by including these topics in Continuing Medical Education (CME) curricula. The establishment of the interoperability health data system will ensure the availability of additional epidemiological data for public health surveillance and response facilitating the early detection of climate sensitive communicable diseases (particularly VBDs such as malaria, and Dengue) but also help pick up epidemiological shifts in less well recognized climate related health impacts for example those related to NCDs and extreme heat or poor air quality (due to windborne dust) or nutrition related issues.

84. **This Program will implement mitigation solutions to the climate challenge through the following activities.** Through the DLI1 requirements for construction, infrastructure, environmental and energy savings, there are important opportunities to mitigate greenhouse gas emissions from the health sector. The DLI will require full energy audits of large health facilities, as well as simpler walk through audits for smaller facilities. Tree planting on health sector land will contribute to carbon sequestration, as well as provide important adaptation benefits through shading (providing heat protection) and reducing flood risk from extreme precipitation. Mitigation topics in medical and nursing school curricula (as well as other

health professional training protocols) in CME will be delivered alongside the adaptation components mentioned above.

Social System

85. **The Program is expected to generate substantial social benefits**, particularly through its efforts to improve quality and efficiency in the provision of health services, as well as in advancing mechanisms to include eligible migrants.

86. **Vulnerable populations have specific frameworks to reduce inequities that will be supported by program actions.** Ethnic groups and native people, as well as other vulnerable groups have spaces for consultation such as "Tables" and "Protocols" for a socio-cultural adaptation and inclusion of the intercultural approach, where they agree and establish standards of care that respect their ethnic and cultural identity, forms of social organization and linguistic characteristics. The GoC will also support the Indigenous System of Own Intercultural Health (*Sistema Indígena de Salud Propio e Intercultural*, SISPI), and the guidelines with directives and guidance for a socio-cultural adaptation and inclusion of the intercultural approach for Indigenous, Afro-Colombian, Raizales, Palenquero and the Rom people's communities.

87. **For migrants (including approximately 1.63 million Venezuelans) different strategies address their health and health care needs, depending on their status**, among others, including vaccination systems for children, birth care, initial emergency care, etc. In addition, the barriers that persist and that prevent their affiliation with the subsidized health regime for not complying with the requirements set forth in the System of Identification of Potential Beneficiaries of Social Programs (*Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales*, SISBEN) will be addressed through the Program.

88. **Citizen Engagement**. There is a range of existing social participation and citizen engagement mechanisms in effect in the health sector. The Social Participation in Health Policy (*Politica de Participación Social en Salud*, PPSS), aims to guarantee the right of citizens to be informed and have a voice in the decision-making of the sector that affects them, as established by the health statutory law. In addition, vulnerable populations have specific frameworks to reduce inequities and Ethnic groups and native peoples have spaces for consultation. Furthermore, the PQRSD is in place and institutionalized across Government agencies. In the case of MSPS, the "Citizen Service" area oversees the webpage where a petition, claim, suggestion or complaint can be formulated (*https: //www.minsalud.gov.co/atencion/Paginas/Solicitudes-sugerencia-quejas-o-reclamos.aspx*). The PQRSD is processed by the Citizen Assistance Group, in accordance with the guidelines established in Resolution 3687 of August 17, 2016. According to the type of petition, the deadlines are established between 10 and 30 days; to support this output, the Program includes an intermediate indicator for measuring the percentage of citizen consultations and claims submitted and solved on time.

89. **Gender Violence**. As noted earlier, the PND has defined a specific gender-related program area in response to the growing problem of gender violence; the "Equity Pact for Women," with several objectives. The Program will support Objective II of this Pact, related to actions to strengthen capacities at local level to prevent, address and protect women against gender-based violence. The MSPS has classified gender violence as a public health event, since sexual violence is considered a medical emergency and access to medical services is guaranteed regardless of the insurance membership status

of the person. It is the duty of the IPS to attend to the victims and start the complaint process. In addition, the Directorate of Promotion and Prevention and the Directorate of Social Promotion in the MSPS have the mandate to implement preventive and health promotion actions of sexual and reproductive rights, maternal and perinatal health, voluntary termination of pregnancy (related to causes of decriminalization), and prevention of gender violence. The MSPS has designed the intersectoral route for sexual violence that includes intersectoral procedures with five components: detection; derivation or activation of the intersectoral protocol; delivery of health services when sexual violence has occurred; rehabilitation and social inclusion. The Program will promote and monitor the number of municipalities with this intersectoral protocol to respond to gender-based violence in place. In addition, the Program will contribute to strengthening the Integrated Gender Violence Information System (*Sistema Integrado de Información de Violencias de Género*, SIVIGE).[16] The MSPS is also in charge of leading, guiding and providing technical assistance to different actors of the health sector to attend in the medical and the health related to the victims and feed the information system.

Summary of the findings of core ESSA principles

90. **The relevance of the ESSA core principles in relation to the program activities has been assessed by the task team and is summarized in Table 5 below.** Core Principle 1 - General Principle of Environmental and Social Management is relevant to the program activities; in addition, from an environmental standpoint, Core Principle 3 - Protect public and worker safety against the associated potential risks, is to be considered. In terms of social, two additional core principles are applicable to this Program: (i) Core Principle 5 - Due consideration to be given to the needs or concerns of vulnerable groups; and (ii) Core Principle 6 - Avoid exacerbating social conflicts. Core Principe 2 - Impacts on natural habitats and physical cultural resources and Core Principle 4 - Land Acquisition, are not pertinent in this case, as there is no land acquisition and therefore no impact on private assets or livelihoods is expected, and the activities supported by the Program won't have any impact on natural habitats nor cultural resources.

[16] SIVIGE was created to measure the situation of gender violence for different sectors using statistical and epidemiological data and how these can be inputs for public policy decision making.

Table 5. Program Activities and ESSA core Principles

ESSA	Core Principle	Analysis
Environmental	1. Environmental and Social Management	Certain interventions would require sustaining current mitigation actions and approaches to better manage the environmental risk, such as: (a) Issues related to the generation, collection, segregation, storage, transportation, management and disposal of biomedical, solid and hazardous wastes. (b) Collection of information and the timely control linked to the HCW stream, to carry out interventions by making informed and timely decisions (e.g. mass vaccination campaigns, increases in laboratory diagnoses, or surgical or cytotoxic treatments).
Social		The Program is expected to have positive impacts on the health of the population, including the most vulnerable sectors, women and children, adult population, victims and dispersed rural populations. The positive impacts would be achieved through a better quality and efficiency of the SGSSS system.
Environmental	3. Protect public and worker safety against the associated potential risks	The medical practices could expose IPSs and beneficiaries to risks associated with exposure to hazardous materials, infections, radiation, as well as sharp instruments, etc. The mitigation actions are foreseen in the Colombian regulations, specially by the IVCS actions of the health and environmental labor risk. Improvements of the physical and psychosocial work environment, promotion of occupational risk assurance, among others, are within the framework of the General System of Occupational Risks (*Sistema General de Riesgos Laborales*, SGRL). The proposed Program is expected to generate positive environmental benefits in the health sector. It will help improve the quality of health services that cover aspects of better environmental hygiene and waste management, through better access to information and human resources training.
Social	5. Due consideration to be given to the needs or concerns of vulnerable groups	The gaps in the provision of health services to ethnic minorities and indigenous peoples have been identified and assessed by the GoC in the document “Bases of the PND 2018-2022” and in specific documents of the National Council of Economic and Social Policy (*Consejo Nacional de Política Económica y Social*, CONPES), establishing the steps to follow and the key actors involved. The GoC in the framework of the Program will continue processing the SISPI (Comply with Stage II of “Preparation of the Base Document, and validation of the 5th component” and Stage III “administrative act of the MSPS and presentation at the Permanent Concertation Table"). For Afro-Colombian, Raiza and *Palenqueras* communities, and the Rom people the MSPS will conclude with the guidelines for a socio-cultural adaptation and inclusion of the intercultural approach that contemplates their standards of care that respect their ethnic and cultural identity, forms of social organization and linguistic characteristics for each ethnic group.

	6. Avoid exacerbating social conflicts	No exclusion of any group in terms of class, religion or geography is expected for the activities of the Program. In addition, the country's health sector has been responding to the phenomenon of Venezuelan migration since 2015 and has recently strengthened its plan. The attention to returning Colombians, who had left the country as a result of the armed conflict, has also been incorporated. In the case of victims caused by or in relation to the armed conflict, in the individual, family and community spheres, the PAPSIVI has been implemented. The Program will contribute to addressing the concerns that the GoC has developed in the first stage of PAPSIVI for almost six years, and a second stage remains to be implemented. In addition, the Program will help eliminate barriers to allow affiliation to the subsidized health regime by elibile migrants and returnee Colombians.

Consultation and Disclosure of the ESSA Report

91. **The ESSA report was prepared in consultation with several stakeholders**, including representatives from the MSPS, ADRES and other relevant agencies, NGOs, territorial entities and EPSs. A draft ESSA report was shared with the GoC and with civil society by email, for consideration and opinion. The findings of the draft ESSA report were disclosed in a workshop organized in Bogota, at the WBG office, on October 3 and 9, 2019. Participants included representatives from civil society organizations, several Government institutions and organizations, such as the Department of Environmental Health, Office of Social Promotion, the DSF, the International Cooperation and Relations Group, the latter under the cabinet of the Minister of Health, and the Health Technology Assessment Institute (*Instituto de Evaluación Tecnológica en Salud*, IETS).

92. **The participants endorsed the findings of the draft ESSA report**, while emphasizing issues such as the stewardship of the MSPS in the generation of health policies and the implementation of IVCS by subnational authorities. Civil society representatives identified three new vulnerable groups (LGBTI, rare diseases, and women in a condition of lawful abortion) as targets for improved PHC access. A summary of this public consultation meeting and participants is presented in the ESSA report. The revised version of the ESSA report was published for a period of 15 days on the MSPS website, on October 31, 2019. On December 4, 2019, the MSPS's team informed the task team that no further comments had been received on the publication of the ESSA.

93. **The ESSA report, enriched by the interaction of the workshop, was published on the MSPS website[17] on December 4, 2019.** Communities and individuals who believe that they are adversely affected as a result of a WBG supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WBG's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WBG's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WBG non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the WBG's attention, and WBG Management has been

[17] *https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/COP/essa-p169866-colombia-final.pdf*

given an opportunity to respond. For information on how to submit complaints to the WBG's corporate GRS, please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the WBG Inspection Panel, please visit http://www.inspectionpanel.org.

D. Risk Assessment

94. **The overall risk rating for the Program is Substantial.** The most significant area of risk is related to the Government's institutional capacity for implementation and sustainability. Other substantial risks include fiduciary aspects and risks related to Venezuelan migration and its pressure on the financial sustainability of the health system and on the delivery of health services.

95. **Institutional capacity for implementation and sustainability risks.** This risk is rated as Substantial. As mentioned above, the PforR will support an ongoing Government program and no institutional changes are expected from this operation. However, the proposed Program will be the first PforR operation in Colombia. Moving from an input-based model to a PforR represents a significant change in accountability and exposes the MSPS to the risk (albeit marginal) of not receiving funding if the DLI targets are not achieved. In addition, ADRES is a rather new entity created in 2015, and although the cycle of health resources has improved, and transaction costs have been reduced from its creation, the exposure to political and fiscal risks is higher than other entities, such as the MSPS. To mitigate these risks, an implementation support and capacity building plan will be elaborated and agreed with the counterparts. In addition, a Program Coordinator has been appointed to ensure the day-to-day implementation of the relevant milestones related to the DLIs, and a team of key staff will be designated as focal points in the relevant departments of MPSP and ADRES to ensure timely coordination for the activities to support the achievement of the DLI targets.

96. **Fiduciary Risks.** The Fiduciary systems risk (including the risk of fraud and corruption) is rated as Substantial, mainly because the ADRES was only recently created (2015) and its operational payment systems and processes are still being developed. The risk will be reviewed based on the GoC's accomplishment of the PAP. The fiduciary assessment found that the implementing entities, MSPS and ADRES, have adequate institutional capacity to manage the Program; however, the systems and processes could be strengthened in the following areas: (a) Financial accounting and reporting; due to the large number of income sources that are part of the SGSSS, the complexity of the processes for insurance payments, and the high volume of transactions; (b) Payment processes, including the cleaning of the BDUA, and updating the risk-adjustment methodology that defines the values of the UPC; and (c) the periodic reconciliation of accounts. The MSPS and ADRES are addressing these mainly through the implementation of the end point agreement (*Acuerdo de Punto Final*) stated in the law 1955 of May 25, 2019 of the PND. Mitigation measures to address these risks and possible capacity building actions are included in the PAP.

97. **Other.** Another Substantial risk is due to the migration from Venezuela and its pressure on the financial sustainability of the health system and on the delivery of health services, as this population is expected to keep increasing and demanding additional services to meet basic health needs. Mitigation measures include technical support to design and test innovative health interventions for eligible migrants, as well as the articulation of efforts across social and economic sectors to face the challenges and take advantages of the opportunities brought by this large migration flow.

ANNEX 1. RESULTS FRAMEWORK MATRIX

Results Framework

COUNTRY: Colombia

Improving Quality of Health Care Services and Efficiency in Colombia

Program Development Objective(s)

The Development Objective of the Program is to support improvements in the quality of health care services and in the efficiency of the health system

Program Development Objective Indicators by Objectives/Outcomes

Indicator Name	DLI	Baseline	End Target
Quality			
Percentage of women with breast cancer detected in early stage (IIA) (PND) (Percentage)	DLI 2	55.70	69.00
Efficiency			
Performance Index for public hospitals (Ai Hospitals) (Percentage)		61.00	70.00
Efficieny gains achieved over the period 2020 - 2022 with new regulations in the pharmaceutical market (Text)	DLI 3	0.00	COP 800 billion

Intermediate Results Indicator by Results Areas

Indicator Name	DLI	Baseline	End Target
QUALITY			
Ministerial decree on SOGC has been approved and issued (Text)		2006 Ministerial decree on SOGC	Ministerial decree Updating the SOGC, has been issued
Percentage of women 50 - 69 years of age screened for breast cancer according to defined protocols. (Percentage)		21.20	30.00
Number of low complexity public hospitals technically assisted in the accreditation process (cumulative) (Number)	DLI 1	2.00	60.00
Regulation for training heatlh care personnel in continous quality improvement approved (Text)		N/A	Regulation Published
Interoperability (IO) standards for electronic health records developed and implemented in priority regions (Text)		No definition of minimum interoperability standards	Regulation published defining minimum interoperability standards for electronic health records
Updating regulation of use of telemedicine to improve access to quality care (Text)		NA	Regulation updated
QUALITY AND GENDER GAP			
Percentage of municipalities with an intersectoral mechanism to respond to gender-based violence in place (Percentage)		55.00	70.00
EFFICIENCY			
Development of a prioritization mechanism to update the benefits plan (Text)		NA	New prioritization matrix of Benefit Plan published
Public release of key performance indicators for public hospitals on a quarterly basis (cumulative) (Text)		2 public quarterly releases	14 public quarterly releases
Roll out of pilot for pre-judicial agreements to new departments (Number)		0.00	6.00
Publication of analysis of the pharmaceutical market for the incorporation of medicines and medical devices into the probation regime (libertad vigilada y control directo) (Text)		Bulletin 1	Bulletin 4
MIGRATION			

Indicator Name	DLI	Baseline	End Target
Number of departments with strengthened capabilities to allow the affiliation of migrants to the SGSSS (Number)	DLI 4	0.00	24.00
CITIZEN ENGAGEMENT			
Percentage of citizen consultations and claims submitted through the internet site of the MSPS solved on time according to resolution 3687 of 2016 (PQRSD) (Percentage)		80.00	87.00

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Percentage of women with breast cancer detected in early stage (IIA) (PND)	Numerator: Number of new women detected as invasive carcinomas (breast cancer) in early stages (2A) at diagnosis, as defined in the OM. Denominator: Total women diagnosed with breast cancer invasive	Yearly	Cuenta de Alto Costo (CAC)/ MSPS	CAC is a technical NGO of the Health System where health insurers from both health regimes (Subsidized and contributive) approach high cost diseases, promoting risk management among them. CAC collects this information from Health Insurers, validates it for further analysis.	MSPS
Performance Index for public hospitals (Ai Hospitals)	Ai Hospitals monitors 24 management indicators for public hospitals, of 7 of which correspond to public health indicators of territorial entities and 17 to hospital management.	Yearly	SISPRO	The Direction of Health Services Provision of MSPS, based on AI Hospitals, monitors the evolution of the results obtained quarterly by all public hospitals in aspects such as service quality, budget balance and financial management.	MSPS
Efficieny gains achieved over the period 2020 - 2022 with new regulations in the	Efficiency gains, measured by the difference between	Yearly	SISMED	The Direction of Medications and	MSPS

pharmaceutical market	the regulated price and the original price (as reported in the SISMED), that sum least COP 800 billion.			Technologies in Health (MSPS) generates the bulleting based on SISMED,	

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Ministerial decree on SOGC has been approved and issued	The SOGC is the set of institutions, standards, requirements, mechanisms of the health sector to generate, maintain and improve the quality of health services in the country. A decree will be generated to update the objectives, scope and implementation for quality of care.	Milestone	MSPS	The MSPS will prepare a draft of the norm and have a public consultation for comments, before submitting for Presidential issuance.	MSPS
Percentage of women 50 - 69 years of age screened for breast cancer according to defined protocols.	Numerator: Number of eligible women aged 50 - 69 screened for breast cancer according to define clinical guidelines (with mammogram) Denominator: Total number of eligible women aged 50 - 69	Yearly	SISPRO & Quality of Care Observatory Website.	MSPS report from SISPRO/ Res. 4505.	MSPS
Number of low complexity public hospitals technically assisted in the accreditation process (cumulative)	The objective is to promote the accreditation in low complexity hospitals to increase quality of care provided by primary health providers	Yearly	MSPS	The MSPS will technically assist low complexity hospitals to promote among them the benefits of the accreditation process, which will be	MSPS

				consolidated in periodic reports	
Regulation for training heatlh care personnel in continous quality improvement approved	The MSPS will promote that health care personnel are provided with training in continuous quality improvement through the new regulation.	Yearly	MSPS	The MSPS will monitor the number of health care personnel trained online through its own databases.	MSPS
Interoperability (IO) standards for electronic health records developed and implemented in priority regions	The MSPS will prepare a decree defining key variables to be incorporated in interoperability standards published in official journal. Afterwards, through further and periodic norms (resolutions) the MSPS will be giving technical guidelines to gradually implement IO in the health sector.	Milestone	Official Journal and MSPS webpage	The MSPS will issue decree and resolutions	MSPS
Updating regulation of use of telemedicine to improve access to quality care	The MSPS will update and publish in the official journal a regulation for the expansion of telemedicine so that better quality care can be accessed for Colombians living in rural and remote areas	Milestone	Official Journal and MSPS webpage	Official Journal and MSPS webpage	MSPS
Percentage of municipalities with an intersectoral mechanism to respond to	In order to reduce gender-based violence, the	Yearly	SIVIGE	Progress on indicator will be based on Sivige	MSPS

gender-based violence in place	intersectoral mechanisms (already designed) will reach more municipalities in the country.			system, which disposes statistical information o gender violence, aimed to support the implementation and evaluation of public policies.	
Development of a prioritization mechanism to update the benefits plan	The design and implementation of a a matrix of prioritization, will give more credibility and transparency, and technical strength to update the benefit plan.	Yearly	MSPS	The MSPS will develop a new matrix of prioritization which will be consulted with stakeholders including society of medics, and then published.	MSPS
Public release of key performance indicators for public hospitals on a quarterly basis (cumulative)	The purpose is to increase the number of reports to 4 per year on key performance indicators for public hospitals, to allow more accountability among the hospitals in order to increase efficiency and quality health care.	Quarterly	SISPRO	The MSPS on a quarterly basis will release the report with the performance indicators.	MSPS
Roll out of pilot for pre-judicial agreements to new departments	After the initial success in the reduction of tutelas in the department of Caldas, the objective is to develop this model where the judicial sector, local and national health authorities,	Yearly	MSPS	The MSPS will promote this model with the judicial sector to implement it in other regions of Colombia and will document this process.	MSPS

	EPSs work together to guarantee health right access to beneficiaries, in other regions of Colombia.				
Publication of analysis of the pharmaceutical market for the incorporation of medicines and medical devices into the probation regime (libertad vigilada y control directo)	The MSPS will annually analyze the behavior of markets for the incorporation of medicines and medical devices into the probation regime, including prices, quality and trends.	Yearly	SISDIS/ SISMED	The MSPS will prepare and publish a report on a yearly basis (Bulletins), using SISDIS/ SISMED, which includes sale or supply prices of the medicines and medical devices, included in the probation regime.	MSPS
Number of departments with strengthened capabilities to allow the affiliation of migrants to the SGSSS	The MSPS will provide technical assistance to the departments to increase the affiliation of eligible migrants to the health system.	Yearly	MSPS	The MSPS will provide technical assistance to the departments and will document it in a report	MSPS
Percentage of citizen consultations and claims submitted through the internet site of the MSPS solved on time according to resolution 3687 of 2016 (PQRSD)	The objective is to increase the percentage of citizen consultations and claims submitted through the MSPS's web page, on time according to the norm.	Monthly	Report PQRSD/ ORFEO system	The MSPS will report the percentage of citizen consultations and claims submitted through the MOH's web page and solved on time.	MSPS

ANNEX 2. Disbursement Linked Indicators, Disbursement Arrangements and Verification Protocols

Disbursement Linked Indicators Matrix

DLI 1	Updated and new regulations defining the processes and standards for the certification (habilitación) and accreditation of health care providers and for the accreditation of EPSs			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	46.90	25.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	NA			
Prior Results	Administrative act updating certification (habilitación) standards to be met by health care facilities, including standards for environmental management, published in the Official Journal of the Republic of Colombia.		11.72	
September of 2020	Administrative act defining processes and standards for the accreditation of EPSs that include quality and environmental management standards, published in the Official Journal of the Republic of Colombia		17.59	
September of 2021			0.00	
September of 2022	Administrative act defining quality standards and simplified processes for the accreditation of low-complexity hospitals that include the introduction of environmental management		17.59	

	standards, published in the Official Journal of the Republic of Colombia			
September of 2022			0.00	

DLI 2	Incentives introduced in the payment system to achieve higher quality of care and efficiency			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	46.90	25.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	55.70%			
Prior Results			0.00	
September of 2020	Administrative act with the new ex-post adjustment of the UPC (for breast cancer) published in the Official Journal of the Republic of Colombia		15.63	
September of 2021			0.00	
September of 2022	UPC risk adjustment methodology dully discussed, and resulting technical document published on the MSPS website		15.63	
September of 2022	At time of diagnosis, at least 80% of the progress towards the target of 69% of women with breast cancer detected at stage IIA or lower has been achieved		15.64	See Disbursement Table

DLI 3	Efficiency gains in pharmaceutical expenditure as a consequence of pharmaceutical market regulatory policies			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	46.90	25.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Prior Results	Administrative act (circular) defining the new drug price regulation methodology, published on the MSPS website for public consultation		11.72	
September of 2020	Application of the current drug price regulation methodology (Circular 03 of 2013) to at least 50 new relevant markets		11.73	
September of 2021	egulation (circular) defining the methodology used to control the introduction of high cost drugs in the market (regulation of the puerta de entrada), published in the Official Journal of the Republic of Colombia		11.73	
September of 2022	Regulatory measures implemented lead to efficiency gains, measured by the difference between the regulated price and the original price (as reported in the SISMED), that sum least COP 800,000 million between 2019 and 2022		11.72	See Disbursement Table
September of 2022			0.00	

DLI 4	Number of eligible migrants affiliated to the SGSSS			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Text	46.90	25.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	69,100			
Prior Results	Administrative act from the MSPS defining the conditions in which regularly registered Venezuelan migrants (PEP holder migrants) can enroll in the SGSSS, published in the Official Journal of the Republic of Colombia		11.72	
September of 2020	139,500		11.73	See Disbursement Table
September of 2021	197,000		11.73	See Disbursement Table
September of 2022	225,250		11.72	See Disbursement Table
September of 2022			0.00	

Verification Protocol Table: Disbursement Linked Indicators	
DLI 1	Updated and new regulations defining the processes and standards for the certification (habilitación) and accreditation of health care providers and for the accreditation of EPSs
Description	This indicator has the objective to contribute to enhance and strengthen the quality in health care, by updating the regulation, standards and instruments for certification and accreditation of IPSs and EPSs.
Data source/ Agency	MSPS
Verification Entity	DNP
Procedure	1. Administrative Act published in the Official Journal of the Republic of Colombia, updating certification (*habilitacion*) standards for IPSs, including standards for environmental management, as defined in the OM. 2. Administrative Act published in the Official Journal of the Republic of Colombia,defining quality standards for EPSs, as defined in the OM. 3. Administrative Act published in the Official Journal of the Republic of Colombia, defining the quality standards and simplify process for accreditation for low- complexity hospitals with the introduction of environmental management standards, as defined in the OM.
DLI 2	Incentives introduced in the payment system to achieve higher quality of care and efficiency
Description	This indicator consists of the development and implementation of financial incentives for EPSs to achieve access, quality and efficiency targets related to cancer patients and the cancer system more generally. Financial incentives are distributed ex-post. In addition, consist of an evaluation of the risk adjustment methodology for UPC, for improving efficiency; the process will consider technical criteria and institutional elements, due to the implementation challenges.
Data source/ Agency	CAC/ MSPS
Verification Entity	DNP
Procedure	1. Administrative Act published in the Official Journal of the Republic of Colombia, defining the ex-post adjustment mechanism (for breast cancer) of the UPC (ex-post incentives to EPSs), as defined in the OM. 2. Technical and institutional tables operative (evidenced by signed meeting notes) and resulting technical document published on the MSPS website, as defined in the OM.

	3. Compliance with the progress of the goal established in the PND (see formula in the WBG Disbursement Table), as informed in the CAC, and as defined in the OM.
DLI 3	Efficiency gains in pharmaceutical expenditure as a consequence of pharmaceutical market regulatory policies
Description	This indicator consists in the introduction and implementation of new methodologies for price regulation of medicines, the introduction of high cost drugs in the market (Puerta de entrada), and the analysis of the markets for medical devices incorporated into the probation regime (regimen de libertad vigilada), in order to achieve efficiency savings in the insurance system and allow better coverage of both medicines and medical devices.
Data source/ Agency	MSPS/ SISMED
Verification Entity	DNP
Procedure	1. Publication on the MSPS webpage of the Administrative Act that defines the methodology for the regulation of prices of medicines prior to issuance, as defined in the OM. 2. Administrative act setting new drug prices using the methodology and definition of relevant markets defined by Circular 03 of 2013, published in the Official Journal of the Republic of Colombia, as defined in the OM. 3. Administrative act *(circular)* published in the Official Journal of the Republic of Colombia, defining the methodology used to control the introduction of high cost drugs in the market, as defined in the OM. 4. Calculation of savings according to the drug price report in the SISMED (see WBD Disbursement Table), as defined in the OM.
DLI 4	Number of eligible migrants affiliated to the SGSSS
Description	This indicator has the objective to increase the affiliation of migrants to the health system through the implementation of activities such as the issuance of legal standards and the training of staff in departments in protocols to ensure migrants enrollment.
Data source/ Agency	MSPS/ BDUA

Verification Entity	DNP
Procedure	1.Administrative act published in the Official Journal of the Republic of Colombia, defining the conditions under which migrants from Venezuela that are regularly registered (PEP holder migrants), are eligible to access the SGSSS (new affiliation mechanism), published in the Official Journal, as defined in the OM. 2. Affiliation of Venezuelan migrants (PEP holders) to the SGSSS, subdivided by gender (see WBG Disbursement Table), as defined in the OM.

WBG Disbursement Table

#	DLI	WB financing allocated to the DLI (USD Millions)	Deadline for DLR Achievement[18]	Minimum DLR value to be achieved to trigger disbursements of WBG Financing	Maximum DLR value(s) expected to be achieved for WBG disbursements purposes	Determination of Financing Amount to be disbursed against achieved and verified DLR value(s) [19]
1	Updated regulation for certification and accreditation of EPS and IPS to improve quality of care, including environmental management standards.	46.9	Any period over the year	DLRs must be fully achieved.	NA	
2	Incentives introduced in the payment system to achieve higher quality of care and efficiency.	46.9	Any period over the year	For periods 2 – 3, DLRs must be fully achieved. For period 4: at time of diagnosis, at least 80 percent of the progress towards the target of 69 percent of women with breast cancer detected at stage IIA or lower has been achieved.	For periods 2 – 3, DLRs must be fully achieved. For period 4; up to 69 percent of women with breast cancer detected early at the time of diagnosis (up to IIA) achieved.	For Period 4: USD 15,633,333 for an increase of at least 19.21 percent in relation to the baseline. or USD 813,812 for each additional percentage point above the baseline, up to USD 15,633,333.
3	Efficiency gains in pharmaceutical expenditure as a consequence of pharmaceutical market regulatory policies.	46.9	Any period over the year	For periods 1 – 3, DLRs must be fully achieved. For period 4, DLR will be disbursed proportionally to the target achieved.	For periods 1 – 3, DLRs must be fully achieved. For period 4, DLR will be disbursed proportionally to the savings achived above or equal to USD 235 million (equivalent	For period 4: USD 117,243 for each COP 8 billion achieved in efficiency gain, up to USD 11,724,333.

[18] Deadline for DLI's achievement is indicative, as DLRs can be achieve and submitted to the WBG prior verification at any time during project cycle. Once the DLR is verified and approved by the WBG the MSPS and MHCP could request the portion of the disbursement involved.

#	DLI	WB financing allocated to the DLI (USD Millions)	Deadline for DLR Achievement[18]	Minimum DLR value to be achieved to trigger disbursements of WBG Financing	Maximum DLR value(s) expected to be achieved for WBG disbursements purposes	Determination of Financing Amount to be disbursed against achieved and verified DLR value(s) [19]
					to COP 800,000 million).	
4	Number of eligible migrants affiliated to health insurance scheme (SGSSS).	46.9	Any period over the year	For period 1, DLR fully achieved. For periods 2-4, DLRs will be disbursed proportionally to the target achieved.	For period 1, DLR fully achieved. For period 2-4, DLRs will be disbursed proportionally to the target achieved up to 225,250 additional migrants affiliated to health insurance scheme.	For Period 2 to 4: USD 156.15 for each eligible migrant affiliated and assigned to the WBG, up to USD 35,173,000.

ANNEX 3. TECHNICAL ASSESSMENT

A. Program's Strategic Relevance and Technical Soundness of the Approach

1. **The Program Development Objective directly contributes to the health sector goals of Colombia's PND for 2018-2022 and to the strategic vision of the MSPS.** The goal of the proposed operation of improving quality and efficiency in the delivery of health care services and, consequently, contribute to strengthening the financial sustainability of the Colombian health system is directly aligned with the health sector goals of the country's PND for the 2018-2022 period. In fact, the objectives of this PforR mirrors the title of the Government's health sector program that it supports: "Health for all with quality and efficiency, sustainable by all." Furthermore, the Program goals and the strategic vision of the MSPS, which contains five areas: (a) long-term perspective; (b) quality; (c) public health; (d) human resources for health; and (e) financial sustainability.

2. **The Program is aligned with the WBG's twin goals of eliminating extreme poverty and boosting shared prosperity by assisting Colombia to accelerate progress towards the achievement of UHC.** It is also closely aligned with the SDGs which stress the importance of achieving UHC and financial protection. The proposed Program is consistent with the Priority Directions of the Health, Nutrition and Population Global Practice 2016-2020 and aligned with the WBG's Human Capital Project, which calls for countries to make greater investments in health and education to improve the productive capacities of their populations.

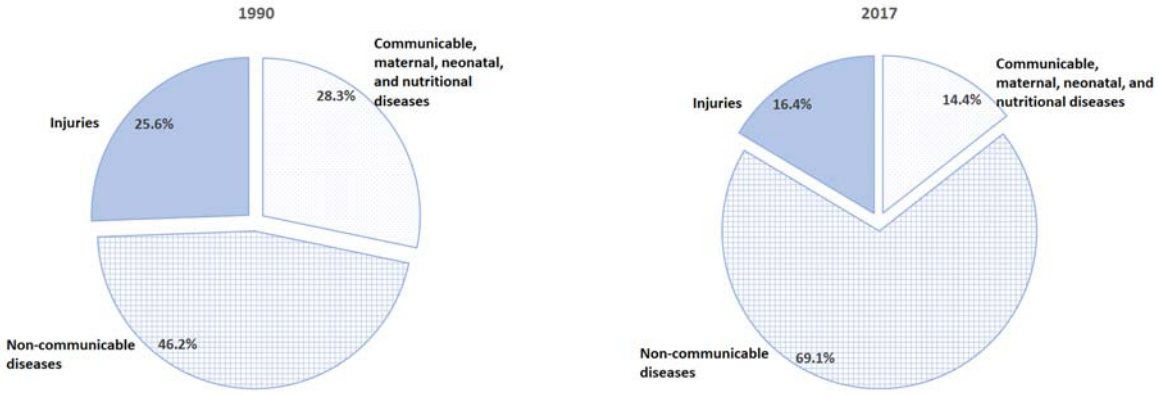
3. **The Program also responds to the difficult economic and social context generated by the oil shock of 2015-2016 and that was exacerbated by the commitments of the peace process and the massive migration from Venezuela.** The economic slow-down produced by the oil shock of the middle of the decade contributed to the deterioration of the fiscal imbalance of the central Government. This already difficult scenario is made more complex by the pressures from post-conflict spending commitments – which according to Government estimates may cost approximately 0.7 percent of the GDP per year – and by the spending related to the important migration flows from Venezuela. This influx of Venezuelan migrants and returning Colombians who had migrated to Venezuela in the 1970's is generating important fiscal and economic pressures and placing a significant burden on institutions, service provision systems, particularly in receiving areas. Contrary to traditional migratory processes, the current inflow, which increased markedly in 2018, is characterized by a very rapid arrival of people and a relatively high proportion of individuals in conditions of socio-economic vulnerability.[20] The demands for health, housing, education and water and basic sanitation services have increased rapidly and are concentrated in areas characterized by pre-existing deficits in service provision. In addition, due to the growth of vulnerable populations, the demand for social protection services in receiving areas tends to exceed existing capacities. The short-term fiscal impact of the migratory process is challenging. It is estimated that, in 2018 alone, between 0.26 percent and 0.41 percent of GDP would be required to provide access to services to the returnees and eligible migrants at a level similar to that provided to the local population. In addition, in the medium term, infrastructure investments would be necessary to expand the network of services in receiving areas, particularly in education, health and water and

[20] As of October 31, 2019, there were 1.63 million Venezuelans in Colombia, including about 719 thousand regular migrants.

sanitation. This implies that additional fiscal consolidation measures over the 2020-2022 period will be necessary, including targeted expenditure containment and rationalization, as well as efficiency-enhancing measures.

4. **The country's demographic and epidemiological transition is generating a rapid increase in the prevalence of chronic or NCDs, which contribute to the growing concern regarding the financial sustainability of the health system and make evident the importance of quality and efficiency improvements.** As the Colombian population ages (demographic transition) and is increasingly exposed to health risks factors such as poor dieting, smoking, drinking and sedentary habits, NCDs have become the main causes of death and disability (a phenomenon known as epidemiological transition), increasing from 46 percent of total years of DALYs lost in 1990 to 69 percent in 2017 (Figure A3-1 below). Approximately 78 percent of all deaths that occurred in Colombia in 2017 were caused by NCDs. Because NCDs are more expensive and difficult to control, they represent an economic and organizational challenge to the health system. In this sense, measures aimed at improving the (technical and allocative) efficiency of the system and the quality of health services are critical to ensure better health outcomes and financial sustainability in a context of population aging and high prevalence of chronic diseases.

Figure A3-1. Burden of Disease by Main Causes (% of DALYs). Colombia, 1990 and 2017

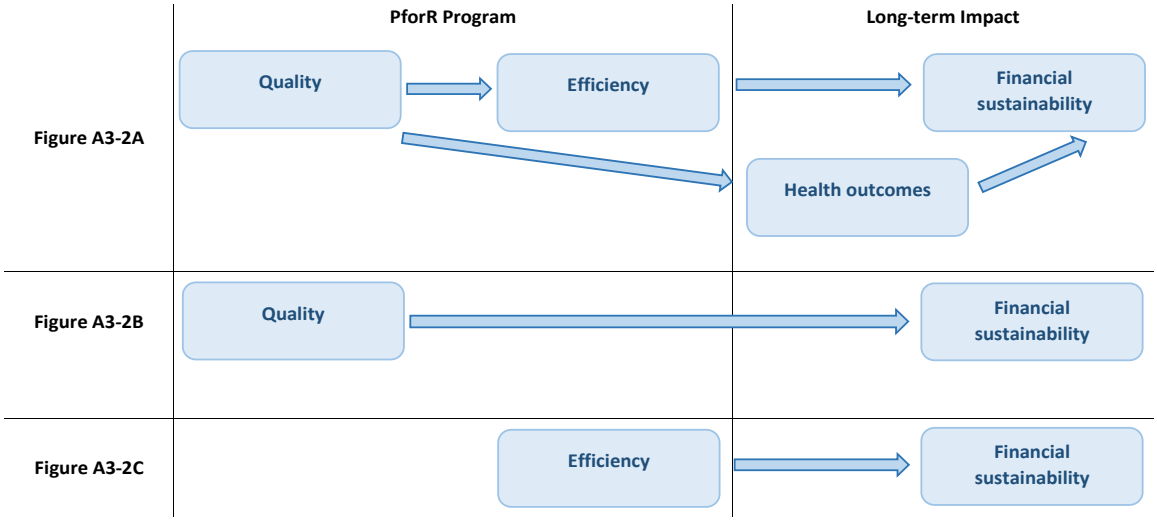


Source: Global Burden of Disease Study 2017. Institute for Health Metrics and Evaluation, 2018.

5. **A low-quality health system is a high-cost health system: quality and efficiency are intrinsically related, and both contribute to the health system's long-term financial sustainability.** First, low-quality of care can be costly in terms of human suffering and loss. Poor quality causes 10 to 15 percent of total deaths in low- and middle-income countries each year It is estimated that between 5.7 and 8.4 million deaths and more than 130 million adverse events occur each year from poor quality of care in these countries (Crossing the Global Quality Chasm. Improving Health Care Worldwide. US National Academy of Sciences, 2018). In the United States, by some estimates, medical errors account for more deaths annually than road accidents and breast cancer combined. In Colombia, it is calculated that approximately 22,000 deaths (65 percent of all deaths attributable to the health care system) are due to poor quality of care. Second, low-quality of care generates waste. A poor-quality health system is technically and allocative inefficient. The need for corrective services, ineffective care and avoidable hospital admissions are major sources of inefficiency. Approximately 15 percent of hospital expenditure in high-income countries is used

to correct preventable complications of care and patient harm. Up to 20 percent of health resources are used in ways that generate very few health improvements. In the United States, 30 percent prescriptions for antibiotics are unnecessary, posing risk to patients, wasting resources and contributing to the global problem of antimicrobial resistance. A study for Colombia estimated that avoidable hospitalization represented almost 22 percent of all discharges in 2009. This result reflects the fact that a timely and effective primary care can reduce and even eliminate the need for hospital admission for several diseases and health problems, thus indicating an inefficient allocation of resources. These connections between quality, efficiency and financial sustainability are summarized in Figure A3-2 below.

Figure A3-2. Relationship Between Quality, Efficiency and Financial Sustainability



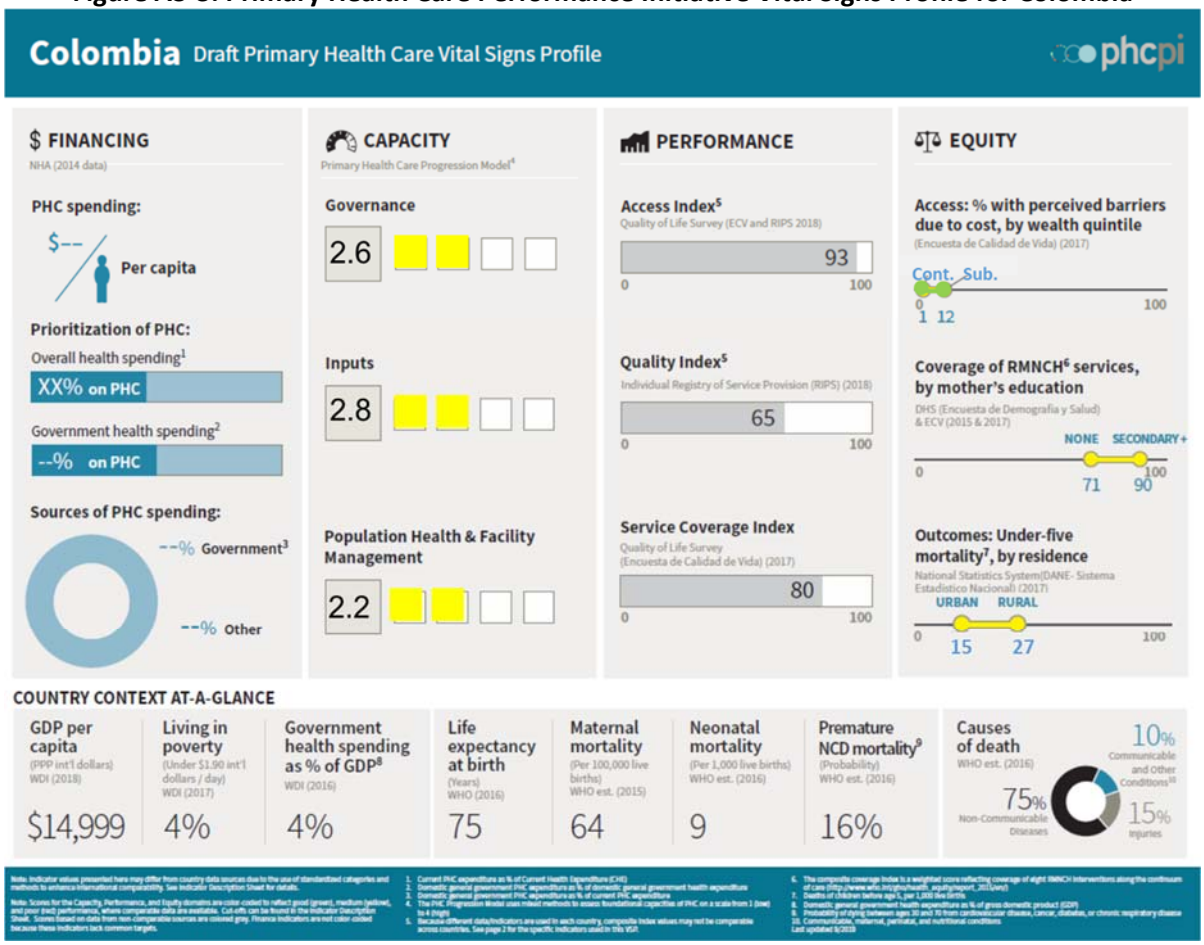
6. **International comparisons show poor quality of care in Colombia when compared to the median of OECD countries.** This problem is compounded by large variations between the public and the private sector, and the urban and rural divide. Pockets of excellence in quality of care evidenced by high levels of sophistication in continuous quality improvement and quality measurement co-exist with a majority of moderate to low-quality health care facilities, with little capacity for continuous quality improvement. However, most components of a comprehensive strategy to improve quality of care are only partially implemented: policies, standards, quality measurement, accountability and human resources, and capacity for continuous quality improvement are only partially addressing quality deficiencies in the sector.

7. **Finally, preliminary findings from the PHCPI exercise suggest that Colombia has achieved high levels of access to PHC but not commensurate results in effective coverage, pointing to two bottlenecks to system performance: the quality of care delivered and the equitable distribution of this care across the population.** Less than 5 percent of the Colombian population reports facing cost or distance barriers to access care when in need and more than 92 percent receive care from a general practitioner within 48 hours of requesting an appointment; these results point to much higher levels of access than in other countries where similar measures are available. Despite the importance of NCDs in Colombia's epidemiological profile, effective care coverage for these illnesses is the largest bottleneck to effective service coverage in Colombia: over 30 percent of the population has uncontrolled hypertension and 50

percent of diabetics have uncontrolled blood sugar levels. The bottlenecks to the delivery of high-quality PHC services lie primarily in the lack of comprehensiveness of the services offered (particularly NCD services) in the first level; in the low adherence of health workers to clinical guidelines and in the lack of continuity of care.

8. The PHCPI methodology has been used, between July and September 2019, to assess the performance of the PHC System of Colombia. The assessment aims to identify strengths and weaknesses in the system with the purpose of developing plans to maintain high performance or defining improvement strategies where bottlenecks are identified. The methodology uses quantitative and qualitative analysis to assess 4 pillars of the PHC system: Financing for PHC, System Capacity, System Performance and Equity.

Figure A3-3. Primary Health Care Performance Initiative Vital Signs Profile for Colombia



9. **Preliminary findings (see Figure A3-3) suggest that Colombia has achieved high levels of access to PHC but not commensurate results in effective coverage, pointing to two bottlenecks to system performance:** the quality of care delivered and the equitable distribution of this care across the population. Less than 5 percent of the Colombian population reports facing cost or distance barriers to access care when in need (*Encuesta de Calidad de Vida*, ECV, 2017) and more than 92 percent receive care

from a General Practitioner within 48 hours of requesting an appointment (RIPS 2018); these results point to much higher levels of access than in other countries where similar measures are available. Although 75 percent of mortality in Colombia can be attributed to NCDs (WHO, 2016), effective care coverage for these illnesses is the largest bottleneck to effective service coverage in Colombia: over 30 percent of the population has uncontrolled hypertension (Quality Observatory 2018) and 50 percent of diabetics have uncontrolled blood sugar levels (RIPS 2018). Coverage for essential infectious disease services and maternal and child health services are delivered to 85 percent or more of the population displaying important achievements but room for continuous efforts.

10. **Bottlenecks to the delivery of high-quality PHC services lie primarily in the comprehensiveness of services offered in first level and low complexity facilities (particularly NCD services), health worker adherence to clinical guidelines and the continuity of care.** Although 45 percent of PHC facilities are licensed to provide a set of essential maternal and child health services, nearly a quarter (26 percent), provide a set of essential services for infectious disease care and even fewer (19 percent) are licensed to provide specific services for NCDs care. Adherence to clinical guidelines in Colombia was measured as the percentage of persons that received a service according to recommendations and findings show important bottlenecks: nearly 35 percent of pregnant women do not receive HIV counseling and testing (Quality of Care Observatory, 2018), 49 percent of women aged 20 to 69 do not receive cervical cancer screening according to guidelines and 33 percent of women aged 50 to 69 do not receive a mammogram according to guidelines (Report for resolution 4505, 2018). Continuity of care measured as continuity in vaccinations and Tuberculosis care also indicates areas for improvement; with a DPT3 dropout rate of over 7 percent (Expanded Immunization Program 2018) and in 2016 a TB treatment success rate of only 60 percent (Emerging, reemerging and neglected disease program, 2016).

11. **Compounding bottlenecks to quality of care, preliminary results for Colombia show moderate yet important differences in equity of PHC across income groups, levels of education and rurality.** Although there have been great achievements in ensuring access to care for all in Colombia, results show that 12 percent of persons affiliated to the subsidized health insurance regime (poor or informal workers) face financial barriers to access health care when in need as compared to 1 percent of persons affiliated to the contributory regime (formal workers and their families) (*Encuesta de Calidad de Vida,* ECV 2017). Similarly, the analysis shows differences higher coverage rates of maternal and child health services for persons with secondary school education (90 percent) as compared to persons with primary school or no education (71 percent) (Demographic and Health Survey, DHS 2015 and ECV 2017). Finally, there analysis also finds differences in under five mortality rates between urban and rural areas (15 versus 27 deaths per 1,000 live births) (National Department of Statistics, *Departamento Administrativo Nacional de Estadística*, DANE 2018).

12. **Preliminary results of the qualitative progression model assessment for PHCPI, suggest that although the system's capacity to deliver care has many achievements, bottlenecks related to the system's ability to adjust to the population's changing epidemiological and demographic profile can be found across the three domains of system capacity**. Findings of strengths and weaknesses of the system's capacity are closely aligned with findings related to the system's performance. Results related to the governance of the PHC System show that Colombia has been able to define strong policies and plans for the health sector overall but not ones specifically targeting PHC. Strong health system policies and plans have resulted in the availability of a strong system for quality monitoring, strong systems for birth and

death registries as well as the good availability, for most of the country, of inputs necessary for service delivery (medicines, equipment, human resources, etc.). Although the PHC system has been able to recruit trained facility managers and has established the bases for patient management through empanelment as defined in the national health policies, facilities and sub-national administrators, continue to struggle with their ability to define local priorities for service provision, ensure community participation and use available data for local decision-making. The inability to garner available data and citizen participation, hence, limits the system's ability to respond to local priorities and needs.

B. Program Goals and Results Chain

13. **The pursuit of the operation's goal of improving quality and efficiency in the delivery of health care services will be monitored and evaluated by three main sets of indicators related to:**

(a) the early detection of breast cancer[21];

(b) the performance of public hospitals; and

(c) the price of medicines.

14. **Breast cancer is the most important type of cancer in women.** It impacts 2.1 million women each year and causes the greatest number of cancer-related deaths among women. In Colombia, breast cancer is responsible for almost 2 percent of the disease burden in women and more than 3 percent of all female deaths (14 percent of all cancer deaths in women). Early detection is critical for improving breast cancer outcomes and survival. There are two early detection strategies for breast cancer: early diagnosis and screening. Early diagnosis seeks to increase the proportion of breast cancers identified at an early stage, allowing for more effective treatment to be used and reducing the risks of death from breast cancer. Early diagnosis requires providing timely access to cancer treatment by reducing barriers to care and/or improving access to effective diagnosis services. Screening consists of testing women to identify cancers before any symptoms appear. Various methods have been evaluated as breast cancer screening tools, including mammography, clinical breast exam and breast self-exam. Screening can contribute to early diagnosis. It is important to note that because screening requires substantial investment and recurrent costs, health systems must ensure that resources are available to sustain it and maintain quality.

15. **The WBG's recently concluded quality assessment of health care in Colombia has found that the effectiveness measures for NCDs care show poor results.** In the case of breast cancer, only 30 percent of women between the ages of 50 and 69 were screened for breast cancer using mammography in the past two years, while the rates of breast cancer screening with mammography in OECD countries range from 42 percent in Hungary to 84 percent in Finland. Furthermore, many evidence-based practices for cancer screening are not well implemented and variations in quality are common.

[21] The evolution of breast cancer is identified through five broader stages (from stage 0 to stage IV) that are further subdivided. Stage II breast cancer indicates a slightly more advanced form of the disease. At this stage, the cancer cells have spread beyond the original location and into the surrounding breast tissue, and the tumor is larger than in stage I. However, stage II means the cancer has not spread to a distant part of the body. In stage IIA one of the following is true: (a) here is no tumor within the breast, but cancer has spread to the axillary (underarm) lymph nodes; (b) the tumor in the breast is 2 cm or smaller and cancer has spread to the axillary lymph nodes; or (c) the tumor in the breast measures 2 cm to 5 cm but cancer has not spread to the axillary lymph nodes.

16. **Public hospitals are vital to the provision of health care in remote areas of the country where geographic, financial and administrative barriers still impact access to such services**. Geographic and financial barriers mostly affect people in remote areas, where communication is difficult, and mobilization is expensive. As these areas are unattractive to private insurers and providers, and therefore not well-suited to Colombia's managed competition model, public hospitals play a vital role in the provision of health services. In this sense, remote and isolated parts of the country require different organizational and supply structures to address the needs of these populations more appropriately. This is becoming evident, for example, in post-conflict and migration areas, where the singular needs of local communities – e.g. those related to mental health issues and to the health needs of ex-combatants, displaced and migrant families – require a vertically integrated model of care that is unlikely to be fulfilled by non-public providers.

17. **The introduction and use of new technologies, particularly medicines, represent an important cost to the system and, as such, a potentially large source of inefficiency.** The cost of medicines represented, on average, approximately 21 percent of the SGSSS total health spending between 2007 and 2017. Until the early 2010s, Colombia did not have a framework to regulate pharmaceutical. This meant that the prices paid by EPSs were de facto unregulated, leading to unreasonable price hikes and cost escalation, which drained public resources and had an important impact on the financial sustainability of the health system. The continued growth of pharmaceutical spending reached an estimated peak of almost 25 percent of total health spending in 2013 and led to the elaboration of a CONPES document on National Pharmaceutical Policy (CONPES 155 of 2012).[22] Since then, Colombia has introduced several measures to improve and strengthen its pharmaceutical policies. However, results in terms of access to medicines and total spending have been mixed and the country still needs to further develop its capacity to supervise and monitor pharmaceutical services. While advances have occurred in the pharmaceutical sector, Colombia still lacks the tools to evaluate the effectiveness and economic and budgetary implications generated by the introduction of medical devices into the health system, as well as their appropriate use.

18. **The proposed Program aims to achieve its PDO by addressing institutional constraints that hinder quality of care and efficiency in the health sector.** Theories of change for each results area are presented in Figure 1 of the main text.

C. Program Expenditure Framework

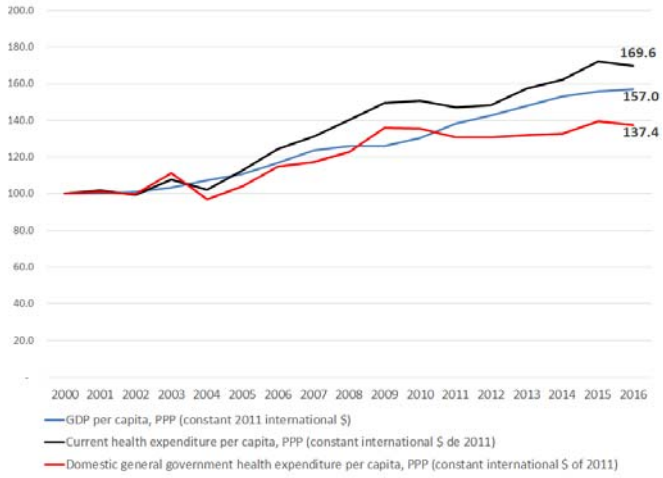
19. **Colombia's levels of health spending are not high, particularly when compared with the OECD.** Total current health spending is only 5.9 percent of GDP, while the OECD average is 12.6 percent and the Latin American average is 8.5 percent (2016 data). This implies that the OECD countries spend on health, on average, six times more per person than Colombia (the average GDP per capita of the OECD is approximately three times Colombia's).

20. **However, per capita health spending has been growing faster than income per capita.** Figure A3-4 shows that per capita (total) health spending has grown faster than income per capita since the year

[22] CONPES is the country's highest national planning authority and acts as an advisory body to the Government in all aspects related to economic and social development. CONPES' policy principles and recommendations are submitted in a document for Council's approval.

2000. The figure also shows that Government spending has not grown as fast and, in fact, has essentially leveled-off during the second half of the series.

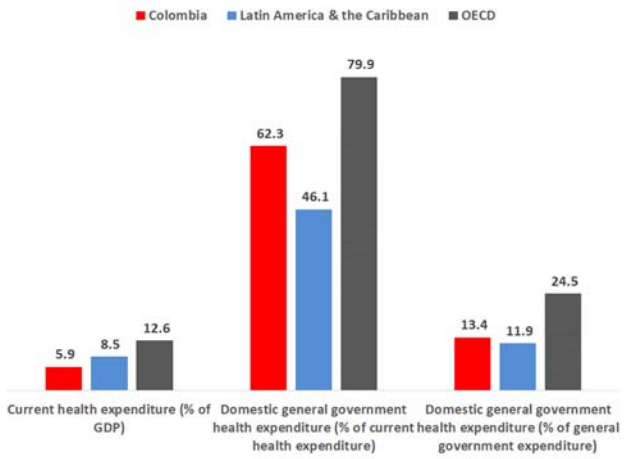
Figure A3-4. Per capita Spending Trend in Relation to GDP per capita. Colombia, 2000-2016 (2000 = 100)



Source: WB, World Development Indicators

21. **In Colombia, the Government has a larger participation in the financing of the health sector than the Latin American average. But still less than the pattern observed in the OECD.** As shown in Figure A3-5, the Government is responsible for approximately 62 percent of total current health spending in Colombia, while the Latin American average is 46 percent. The OECD average, however, is almost 80 percent. The figure also shows that health spending consumes a slightly larger share of total Government spending than the Latin American average (but again, this share is significantly smaller than the OECD average).

Figure A3-5. Selected Summary Health Spending Data. Colombia, Latin America and the Caribbean and OECD, 2016

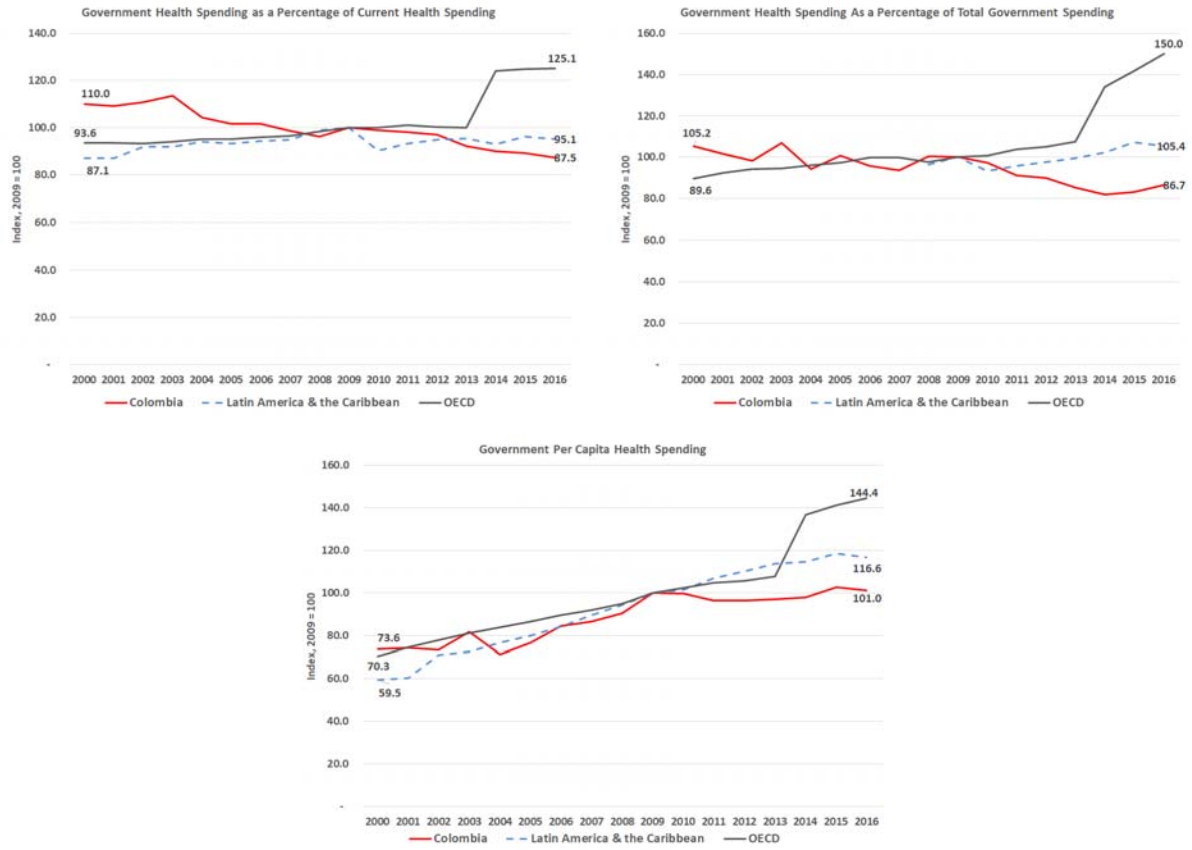


Source: WB, World Development Indicators

22. **The data presented in the last two figures indicate that private spending has been the largest driver of health spending growth since 2000.** Unfortunately, this tendency is reflected in the growth of out-of-pocket spending, which has grown more than 52 percent between 2000 and 2016. It must be noted, however, that at 20 percent of current health spending, out-of-pocket spending is significantly lower than the Latin American average (37 percent in 2016), but more than 40 percent higher than the OECD average (13.9 percent of current health expenditure in 2016).

23. **In this sense, perhaps the most striking pattern observed in recent years is the important negative trend in Government health spending, particularly since 2009.** Figure A3-6 shows that public sector health spending trend has either grown significantly less than the Latin American and OECD averages or declined. While there are many factors that may explain this phenomenon, two elements have certainly contributed to it: the first one is the beginning of the regulation pharmaceutical prices. As noted earlier, until the early 2010s, Colombia did not have a framework to regulate pharmaceutical prices. This meant that the prices paid by EPSs were de facto unregulated, leading to unreasonable price hikes and cost escalation, which drained public resources and had an important impact on the financial sustainability of the health system. This result shows the importance and potential impact of efficiency measures on the sustainability of the health system. The second element that helps explain the observed pattern of public sector health spending is the increased effort of the Government in controlling its spending.

Figure A3-6. Trends in Government Health Spending. Colombia, Latin America and the Caribbean and OECD, 2000-2016



Source: WB, World Development Indicators.

24. **Program Boundaries.** The PforR will support specific results under the objectives I, III, V and VI of the Government program for health established in the PND 2018 – 2022, and objective II of the PND's pact for women, which relate to improving quality and efficiency in the SGSSS, to ultimately contribute to improvements in population health, especially in women's health. The Program will focus its support in the health sector stewardship and managerial function of the MSPS and will support the development of policies and regulations related with the improvement of the mandatory insurance scheme to achieve the expected results during the three-year 2020-2022 period. Furthermore, the proposed PforR will be structured around two results areas; Results area 1: improve the quality of health care services; and Results area 2: improve efficiency in the health system. The link among the Government program and the PforR result areas is described in Table 2 of the main text.

25. **Expenditure Framework.** The total public resources assigned in the PND for the health sector objectives amount to COP 119,0 trillion (approximately USD 35 billion) for the period 2019 – 2022, organized in five budgetary programs that involve current expenditures and investments. The expenditure framework for the PforR would marginally finance current expenditures under the SGSSS' health insurance (*aseguramiento en salud*) budget line related to the subsidized regime for three years, 2020 to 2022, to cover expenditures related with the management of the scheme. The Government amount

associated with this expenditure is estimated at 10 percent of the total amount assigned to the subsidized regime (which corresponds to USD 1,955 million; 99 percent of the expenditure framework). This is aligned with provision stablished under Law 1438 of 2011 that defines 10 percent as the maximum proportion of the UPC that EPSs could assign to administrative expenditures. In addition, the PforR's expenditure framework would include a portion of personnel salaries for three years (2020 – 2022) needed to implement the proposed interventions. The Government amount associated with this expenditure is estimated at 50 percent of the total amount assigned to personnel salaries (which corresponds to USD 28 million; 1 percent of the expenditure framework); personnel salaries are assigned proportionally to the total amount assigned to the subsidized insurance regime out of the total amount assigned to the Government program's health sector objectives as shown in Table A3-1. IBRD financing is USD 150 million, with additional financing of USD 37.6 million from the GCFF.

26. It is important to highlight that the portion assigned to the subsidized regime (99 percent of the expenditure framework) consists of transfers related to a predetermined UPC, multiplied by the insured population duly documented in the BDUA. The purpose of this UPC is to finance the provision of health insurance to the population, which ADRES transfers to the EPSs; the insurance providers. In addition, the expenditure framework includes MSPS personnel salaries needed for the execution of the Program-related activities (1 percent of the expenditure framework). No procurable items, consultancies or technical assistant are included in the Program expenditure framework.

27. **The funding for the Program is adequate, sustainable and aligned with the intended results under the Program's Result Framework**. The activities and expenditures under the Program will be funded from the budget assigned by the MHCP to the MSPS. This budget has been analyzed and has been found to be fully budgeted and executed over the years, since it pays for the UPC of those affiliated to the SGSSS. The MSPS is constitutionally mandated to pay for those affiliated to the subsidized regime. In its sentence T-760 of 2008, the Colombian Constitutional Court ordered the MSPS to equalize the benefit plans of the subsidized regime to the contributive scheme.

Table A3-1. Estimated Three-Year Budget of the Program

PROGRAM: Health for All, with Quality and Efficiency							Total		Expenditure Framework 10% assigned for management costs& 50% for salaries	
SUBPROGRAM: Insurance and Management of the SGSSS										
	2020		2021		2022		2020 - 2022		2020 - 2022	
Concept	**COP$ Billion**	**US$ Million**	**COP$ Billion**	**US$ Million**	**COP$ Billion**	**US$ Million**	**COP$ Billion**	**US$ Million**	**COP$ Billion**	**US$ Million**
CURRENT EXPENDITURES										
Health Insurance (Laws: 100, 1993; 1122, 2007; 1393, 2010; 1438, 2011 and 1607, 2012)	**21,307**	**6,267**	**22,134**	**6,510**	**22,998**	**6,764**	**66,439**	**19,541**	**6,644**	**1,955**
Current Expenditure	19,878	5,847	20,649	6,073	21,455	6,310	61,983	18,230	6,198	1,826
Current special funds	1,429	420	1,485	437	1,543	454	4,456	1,311	440	129
Salaries	**62**	**18**	**64**	**19**	**66**	**19**	**191**	**56**	**96**	**28**
	21,369	6,285	22,198	6,529	23,064	6,783	**66,630**	**19,597**	**6,740**	**1,983**

Note: The Health Insurance's budget line (SGSSS) comprises of two items that differs in the source of the funds: (i) Current Expenditures from the GoC general revenues and (ii) Current Special Funds, earmarked taxes for the health sector.
Source: Own calculations based on MHCP 2019 budget and MSPS projections on the insured population under the subsidized regime for years 2020 to 2022.

28. **The Program will be implemented by the MSPS which will provide overall oversight of Program execution through.** The MSPS is responsible for overall stewardship of the health system; as so, develops norms, standards and guidelines needed by the health insurance agencies and services providers and gives technical assistant to apply them. The MSPS also regulates quality standards and the accreditation system

for EPSs and IPSs. The MSPS stablishes the regime for EPSs and IPSs to purchase, supply and extend the provision of health care services. In addition, the MSPS will be responsible for high level coordination with the other actors involved with Program implementation. The role of these other institutions is described in Table A3-2 below.

Table A3-2. Role and Responsibilities of Entities linked with the PforR's DLIs

#	DLI	Responsibilities of Participant Entities linked with Program DLIs		
		MSPS	ADRES	EPSs
1	Updated regulation for certification and accreditation for EPSs and IPSs to improve quality of care, including environmental management standards and disaster readiness.	MSPS will update the certification of health care facilities standards and the accreditation standards for EPSs and low complexity hospitals, will conduct the consultation process, and will approve and publish in the official journal the final standards.		EPSs will comply with the accreditation standards regulated by the MSPS.
2	Incentives in payment systems to achieve better quality of care and efficiency.	MSPS will design an ex-post financial incentive for the EPSs to promote the earlier detection of breast cancer. MSPS will issue a new regulation for the ex- post adjustment to the UPC and will publish it in the official journal. MSPS will monitor the implementation trough the nominal clinical registry (CAC). MSPS will summon technical and institutional working groups with national and international experts and respresentatives of key stakeholders to propose a new risk adjustment methodology for the UPC. MSPS will publish the techical document on the MSOS website.	ADRES will apply the ex – post adjustment to the UPC according to the results informed by the nominal clinical registry (CAC) and will transfer the adjusted UPC to the EPSs.	EPSs, as insurance companies, will implement the necessary actions in terms of better quality of care related with early detection of breast cancer to get the ex-post incentives (linked to the UPC).
3	Efficiency gains in pharmaceutical expenditure as a consequence of policy and regulatory changes in the pharmaceutical market.	MSPS will design a new methodology for price regulation of medicines and publish the administrative act for public consultation. MSPS will design a new methodology for setting the entry price of high cost medicines and publish it in the official journal. MSPS will calculate the savings according to the drug price report in the SISMED.	ADRES will apply the regulation when transfers payments to the EPSs.	EPSs, as insurance companies, will receive the UPC related to the enrolled population, for the provision of the health insurance.

#	DLI	Responsibilities of Participant Entities linked with Program DLIs		
		MSPS	ADRES	EPSs
4	Number of eligible migrants affiliated to health insurance scheme.	MSPS will design a new affiliation mechanism for migrants from Venezuela that are regularly registered (PEP). This mechanism will be issue by Ministerial Decree as a PforR prioir action. MSPS will communicate the new mecahnism to EPSs and ETs and will monitore the enrollment of new migrants.	ADRES is responsible for maintaining the consolidated database for enrollees to the SGSSS and will verify and inform the enrollment of new migrants.	EPSs will be the insurance companies in charge of enrolling the eligible migrants.

D. Economic Justification of the Program

29. **The economic analysis of the Program was conducted using a CBA to determine if its economic rationale is sound.** CBA expresses costs but also benefits in monetary terms, adjusted for the time value of money and it's mainly used to determine the soundness and rationality of investment/decision (justification/feasibility) and allows for comparison with other projects. The CBA proposed here follows four main steps: (a) Identification of Program's interventions to be analyzed, which in this case are related to DLIs; (b) Identifications of costs related to each intervention (here the loan flow); (c) Temporal projection of resources relevant to impact and interventions; and (d) Estimation of the difference between the NPV of both costs and benefits, also called the net benefits of the program. In these projects a CBA translates the health gains achieved by a program or intervention into monetary terms. The standard economic approach for quantifying the benefit of better health in monetary terms is based on the concept of the "value of statistical life" (or life-year).

30. **The benefits and costs accounted for in this program were modeled using a macro-fiscal, systemic and demographic scenario.** The proposed framework projects a scenario of the Colombian context initially for the length of the project (3 years) but also in a period of 12 years, from 2019-2030, which includes projections of macroeconomic, demographic, systemic and epidemiological (burden of disease) variables, given that demographic and macroeconomic trends influence the results and comparability of an economic evaluation, (e.g. monetization of health benefits). Official estimations for middle term fiscal projections,[23] (from MHCP and the Central Bank) of macroeconomic variables such as inflation, exchange rate and GDP growth were utilized, whereas demographic projections, such as population growth and life expectancy, were taken from DANE.[24] Lastly, health system-related and epidemiological variables were modeled using official information disclosed by the MSPS and international sources such as the Global Burden of Disease – Institute for Health Metrics (GBD-IHME) and the WBG Data Repository. Available evidence suggested the nature, magnitude and trend of the modeled effects. The nature of the health system in Colombia (decentralized and built around insurance) does not

[23] See *https://www.minhacienda.gov.co/webcenter/portal/SaladePrensa/pages_DetalleNoticia?documentId=WCC_CLUSTER-115802*

[24] See *https://www.dane.gov.co/index.php/estadisticas-por-tema/demografia-y-poblacion/proyecciones-de-poblacion*

allow for a direct measurement of typical health care interventions, but rather through policy and regulatory interventions.

31. **For the CBA, two general type of benefits are applied.** The first one is derived from the reduction of burden of disease. Some of the interventions supported by the program have been proved to reduce disease burden (expressed in DALYs) due to combined reductions in both mortality and morbidity. A DALY is defined as one lost year of "healthy" life, and the sum of these DALYs across the population represents the burden of disease, which functions as the measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. DALYs are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with health conditions or its consequences. DLI 1 and the first and third DLRs of DLI 2 comprise actions that can potentially reduce the burden of disease and therefore were modeled in the evaluation.

32. **The second type of economic benefit is monetary, through expected reduction in total costs for the whole system.** There are expected monetary benefits from cost reductions of interventions supported by the program, which are to be measured through the second DLR of DLI 2, DLI 3 and DL4. The first one has the potential of reducing overall costs in the system by spreading more effectively the risk across users in systems, which has been consistently linked to cost reduction and more efficiency on insurance-based systems (with either explicit or implicit benefit packages) and improved resource pooling. DLI 3 states a specific goal of cost reduction, which is to be achieved by the third year of the program and is explicitly stated in the design of the indicator (see Annex 2). DL4 creates savings by introducing risk adjustment and resource pooling from the enrolment of migrants into the SGSSS, as opposed to the basic (and limited to emergencies) fee-for-service coverage currently provided to migrants.

Assumptions of the analysis

33. **The economic evaluation relies on the following assumptions:**

i. **Temporal horizon.** For simplicity, the benefits and costs were modelled for the length of the project (3 years). The program will only disburse from 2020 through 2022, but both monetary and health impacts of the program are expected to continue after the closing of the operation, for which a period of 12 years (2019-2030) was also modelled.

ii. **Benefits.** As stated, the program contemplates direct and indirect monetary benefits;

(a) **DALYS:** The benefits from reductions of DALYs are accounted for the project duration (3 years) and of the extended projection (2030). The monetary value of a DALY is typically equivalent to the value of the country's annual GDP per capita. In this case, the value for 2019 is USD 6,786. Reductions in DALYs from DLI 1 were estimated after computing the joint impact in the country's global burden of a list of 26 diagnostics subject to improvements in quality care (particularly in PHC), and then modelling 3 scenarios of improvement, assuming a global positive effect of the intervention (as reduction in burden)[25]. Approximately 14.2 percent of total health-care related GBD was found to be sensitive to reductions. The health care related GBD comprises NCDs and Communicable diseases, as well as maternal conditions, and together represent 86 percent of the total

[25] See GBD (2018) "Measuring performance on the health care access and quality index" and WHO OECD WB (2018) "Delivering quality in health care".

disease burden of 2017. Finally, scenarios with positive effects were applied to 11.9 percent of total disease burden.

For DLI 2, the effects of the intervention were estimated to the total burden attributed to breast cancer, which is rather small (0.104 percent in 2017); different ranges of conservative effects were estimated (1 percent, 2 percent and 3 percent)[26].

(b) **Monetary:** Three DLIs have the potential of achieving monetary benefits in terms of averted costs or savings. For the second DLR of DLI 2 (UPC design), an alternative comparative scenario for system expenditure was built (alla counterfactual), where the percapita value is kept unaltered, correcting for age structure (to account for age effect in costs). Three scenarios with conservative effects in terms of deviation of the cost per capita were modelled (0.5 percent, 1 percent and 2 percent), following international evidence[27]. Here the potential benefits are very large, due to the volume of resources tied up to the UPC. For DLI 3, an explicit goal of savings (COP 800 billion) has been agreed upon, which comes from the PND 2018-2022 (DNP). The stipulated value of the savings has been duly converted to dollars and discounted. The savings from DLI 4 (SGSSS enrolment of migrants) have been computed as the present value of the difference between the average annual value of the UPC-S for the coverage goal of DLI 4 (see Annex 2) and an estimated per capita annual value of emergency services provided to migrants in the current scheme (source MSPS and DNP).

iii. **Discount rate.** The discount rate should account for inflation and the general opportunity cost for investments in a typical scenario. Monetary benefits and benefits derived from health effects are usually discounted at the same rate, although national guidelines from OECD countries vary.[28] In this evaluation, at the baseline, a 4 percent real discount rate is utilized, although different rates of discount are used in the sensitivity analysis.

iv. **Coverage of the system.** The projections for system coverage come from official estimates of the MSPS for both contributory and subsidized regimes for the length of the project. Including coverage of exception regimes (e.g. teachers, Army, etc.), the system would reach approximately 98 percent of population of the country. From then on and until the end of the extended scenario (2030), the model assumes a progressive increase of the coverage until 99 percent is reached, not accounting for non-enrolled populations from specific population groups (such as indigenous, migrants, outlaws etc.).

v. **Disbursements.** The analysis considers that the funds will be released evenly according to the disbursement table available in Annex 2. It is expected that the total disbursements will be completed in 2022.

(a) **Macro variables.** The analysis uses the economic growth rate of 2.1 percent, a conservative scenario adopted by the MHCP in its long-term estimations, as well as an average inflation rate (end of year) of 3 percent. Population projections from the DANE – updated from the 2018 Census – show a declining population growth towards 2030 and a life expectancy of 79.6 years at the end of period.

vi. **NPV calculations.** The NPV is calculated for the reductions in DALYs until 2022, although impacts

[26] Many positive effects of screening in reduction of disease burden have been documented. See Rashidian et al (2017), Ekwueme et al 2017.

[27] See Wrathall & Belnap (2017) and Nghiem et al (2017).

[28] Attema et al 2018. Discounting in economic evaluations. PharmacoEconomics (2018) 36:745–758. https://doi.org/10.1007/s40273-018-0672-z

from program implementation are expected to go beyond the disbursement period (2030). At baseline scenario, the NPV have been estimated using different values (see Table A3-3). Monetary benefits from DALY's are discounted at a lower value than monetary flows, as reflected in the sensitivity analysis, according to standard international practice.

34. **The results show that the program is highly cost-effective. In the base scenario, reductions in DALYs derived from the program are expected reach 16.4 thousand DALYs, which could be translated into a NPV of benefits close to USD 200 million** The program is highly cost-effective, since it widely exceeds the threshold set for this category[29], achieving unusually high internal rates of return. This result can be explained by the relatively low amount of investment required to generate a high impact in a system like the Colombian one, where the provision and risk management are delegated to private actors and the interventions are often focused on regulation, but with a very high expected marginal return, and the potential to achieve large impacts.

Table A3-3. Results CBA with scenarios

Concept	Base SC	Low Sc	High Sc
NPV Costs (USD millions)	170.2	164.4	176.4
NPV Benefits (USD millions)	383.2	273.2	552.5
NET BENEFIT	213.0	108.8	376.1
INTERNAL RATE OF RETURN	1.9	1.3	2.9
TOTAL DALY'S SAVED	16,033.7	9,964.5	20,155.3
BENEFIT COST RATIO	2.3	1.7	3.1
TOTAL DALY'S DISCOUNTED VALUE	**98.3**	**58.0**	**130.2**
TOTAL DISCOUNTED MONETARY SAVINGS	**285**	**215**	**422**
Total DALY (as % of base year 2017)	**0.15%**	**0.1%**	**0.18%**

35. **Sensitivity analysis.** The sensitivity analysis increases the confidence range by estimating the vulnerability of the program to high variability of key assumptions. Three scenarios were modeled in the analysis using a different set of effects for DLI-related interventions, except for DLI 3, where the savings goal is explicitly set. Given the relatively stability observed in terms of GDP growth and inflation, these variables were not included in the modeling of alternative scenarios. The program maintains a high cost-effectiveness, even with extreme low impact in terms of cost reduction and disease burden (low scenario).

[29] The threshold for cost–effectiveness as the cost of the intervention per DALY averted less than three times the country's annual GDP per capita (WHO 2002).

Table A3-4. Sensitivity analysis scenarios

Concept	Base SC	Low Sc	High Sc
Discount rate savings	*6.00%*	*8.00%*	*4.00%*
Discount rate enrolment DLI 4	*3.00%*	*4.00%*	*2.00%*
Discount rate DALY'S	*3.00%*	*4.00%*	*2.00%*
DALY REDUCTIONS			
IPS and EPS Accreditation Manual			
Annual reduction in DALY's	*0.80%*	*0.50%*	*1.00%*
Breast cancer detected at stage IIA or lower			
Annual reduction in DALY's breast cancer	*2.00%*	*1.00%*	*3.00%*
MONETARY REDUCTIONS			
UPC risk adjustment methodology			
Percapita cost reduction	*1.00%*	*0.50%*	*2.00%*

E. Technical Risks and Mitigation Measures

36. **Technical Design Risks:** The technical design risk is rated as low. The operation will support an ongoing Program that does not contemplate radical design changes to the system. In order to comply with the indicators, several regulatory changes are expected to be implemented by the MSPS, which has shown technical proficiency to conduct these tasks, and also benefits from the political legitimacy resulting from their inclusion in the PND.

37. **Institutional capacity for implementation and sustainability risks.** This risk is rated as Substantial. As mentioned above, the PforR will support an ongoing Government program and no institutional changes are expected from this operation. However, the proposed program will be the first PforR operation in Colombia; moving from an input-based model to a PforR represents a significant change in accountability and exposes the MSPS to the risk (albeit marginal) of not receiving funding if the DLI targets are not achieved. In addition, ADRES is a rather new entity created in 2015, and although the cycle of health resources has improved, and transaction costs have been reduced from its creation, the exposure to political and fiscal risks is higher than other entities, such as the MSPS.

38. **Other Risk related to Venezuelan migration is rated as Substantial**, due to its pressure on the financial sustainability of the health system and on the delivery of health services.

39. **To mitigate these risks, an implementation support and capacity building plan will be elaborated.** A Program Coordinator will be appointed to ensure the day-to-day implementation of the relevant milestones related to the DLIs, and a team of key staff will be designated as focal point in the relevant departments of MPSP and ADRES to ensure timely coordination for the activities to support the achievement of the DLI targets. In addition (as mentioned in Section III, D. Program implementation – Capacity Building, from the main text), implementation support will be provided as well as key capacity building activities through: (a) the implementation support budget; (b) the WBG initiatives already mentioned such as PHCPI and *SaluDerecho*; (c) the use of WBG-managed trust fund resources such as Access Accelerated in the area of pharmaceuticals; and (d) the use of EFO, such as the one that is being

developed with UnitedHealth Group for the methodological assessment and revision of the UPC. Resources from the SPF are supporting TA for training and other capacity development efforts to strengthen the sector's ability to address some of the challenges related to the Venezuelan migration.

ANNEX 4. FIDUCIARY SYSTEMS ASSESSMENT

Section 1: Conclusions

1.1 Reasonable assurance

1. The Fiduciary Systems Assessment (FSA) for the "Improving Quality of Health Care Services and Efficiency in Colombia" Program (the Program) has been conducted and their conclusions are reflected below. The Program expenditure framework will support transfers to finance the health insurance system in Colombia as managed by the MSPS through the ADRES. The FSA was carried out in accordance with the WBG Policy dated November 2017, WBG Directive dated July 2019, WBG Guidance PforR FSA Guidance Note dated June 2017; and Interim Guidance Note Systematic Operations Risk-Rating Tool (SORT) dated June 25, 2014. The WBG determined that the Fiduciary Systems capacity and performance are adequate to provide reasonable assurance that the funds will be used for the intended purposes. Nevertheless, the environment of the Program fiduciary systems still presents some risks that are being addressed by the GoC and are part of the PAP as mitigating measures.

2. This FSA reviewed the capacity and performance of the implementing entities MSPS and ADRES on their ability to: (a) record, control, and manage the Program resources and produce timely, understandable, relevant, and reliable information for the Borrower and the WBG; and (b) ensure that implementation arrangements are adequate, and risks related to financial management, fraud and corruption, as well as the complaints handling mechanisms are reasonably mitigated by the existing framework. Regarding the Procurement aspect of the FSA, no procurable activities were identified within the Program expenditure framework.

3. The Program will mostly finance a portion of the UPC[30] covering expenditures related with the health insurance scheme. This insurance scheme is managed by the MSPS and administered by ADRES. Funds will follow the Government's budgetary system in which the MSPS executes the budget line transferring the funds to ADRES. ADRES has then the responsibility to pay the UPC to the entities providing insurance under the regime. The payments are calculated based on a single database of people covered by the health insurance system, the BDUA. The MSPS and ADRES have internal controls in place to determine the correct calculation of the UPC under the per-capita insurance system and those are subject to Government control mechanisms that apply to the overall per-capita insurance system.

4. Institutional controls over the Program include internal control procedures at MSPS and ADRES, external audit from the CGR and Anti-Corruption mechanisms, that are being considered for this FSA for the use of country systems for the design of this operation.

5. The ADRES is a special decentralized entity of the Executive Branch of the national order, affiliated to the MSPS with legal, administrative and financial autonomy, independent assets[31]. ADRES is currently

[30] The UPC is the annual value recognized by each of the members of the SGSSS to cover the benefits of the POS, in the contributory and subsidized schemes.
[31] ADRES legal structure is stated in the article 66 of Law 1753 of 2015.

responsible for the administration and payments of the SGSSS resources, including the UPC. For that purpose, the MSPS transfers the Program funds to the ADRES, in the form of monthly Units of Payment by UPC times the number of affiliates, as registered in the BDUA, and other resources of the compulsory health insurance system. Updated information from the BDUA is the main input for the recognition of the UPC made to SGSSS entities. The Program will finance SGSSS' health insurance (*aseguramiento en salud*) budget line related to the UPC subsidized regime for three years, 2020 to 2022, to cover expenditures related with the management of the scheme. this expenditure is estimated at 10 percent of the total amount assigned to the subsidized regime (which corresponds to USD 1,955 million; 99 percent of the expenditure framework). In addition, the PforR's expenditure framework would include a portion of personnel salaries needed to implement the proposed interventions. The Government amount associated with this expenditure is estimated at 50 percent of the total amount assigned to personnel salaries (which corresponds to USD 28 million; 1 percent of the expenditure framework.

6. Within the framework of the functions granted by Law, ADRES administers the BDUA. For this purpose, ADRES has developed and implemented mechanisms that prevent the entry of inconsistent information to the BDUA by registering new affiliates or news of existing ones, such as validating processes (network of validation). Additionally, the IT department of ADRES audits the information stored in the BDUA, to detect alleged repeated, multi-affiliation and deceased registration, among others.

1.2 Risk assessment

7. Overall, the Fiduciary systems risk (including the risk of fraud and corruption) is rated as Substantial at this stage, mainly because ADRES was recently created (2015) and its operational payment systems and processes are still being developed. The risk will be reviewed based on GoC's accomplishment of the PAP. The assessment found that the implementing entities, MSPS and ADRES, have adequate institutional capacity to manage the Program; however, the systems and processes could be strengthened in the following areas: (a) Financial accounting and reporting; due to the large number of income sources that are part of the SGSSS, the complexity of the processes for insurance payments, and the high volume of transactions; (b) Payment processes, including the cleaning of the BDUA, and updating the risk-adjustment methodology that defines the values of the UPC; and (c) the periodic reconciliation of accounts. The MSPS and ADRES are addressing these mainly through the implementation of the end point agreement (*Acuerdo de Punto Final*) stated in the law 1955 of May 25, 2019 of the PND. The *Acuerdo de Punto Final* is a set of actions mainly to clean historic debts of the heath system and to make the health spending more efficient and prevent new debts. Among others, the agreement will focus on the implementation of : (a) the reconciliation, verification, and control of the accounts that support health services and technologies not financed with UPC resources of those affiliated with the Subsidized Regime; and (b) the progressive improvement of the effectiveness of health spending, associated with the provision of the service and technologies not financed from the UPC resources. The WBG will follow up the implementation of the *Punto Final* regarding the Program.

8. Outside of the Program boundaries, health services and technologies not funded from UPC resources will be managed by the EPSs from the budget that ADRES would transfer to them for this purpose. As indicated in the PND, the annual budget ceiling by EPS will be established according to the methodology defined by the MSPS, which will consider incentives for the efficient use of resources through the implementation of strategies to optimize the health payment Information systems, and

processes from ADRES to the SGSSS. The *Punto Final* agreement is addressing these issues as mitigation measures to guarantee the financial sustainability of the health system.

9. The 2018 and 2019 financial and special audits carried out by the CGR, to MSPS with a clean opinion and to ADRES with a qualified opinion, included findings which the implementing entities are taking into consideration in compliance with the Improvement plans presented to the CGR. As a mitigation measure for the Program, capacity enhancement will support the CGR to effectively audit program activities at the MSPS and at ADRES during the financing period. The special audit conducted by the CGR included administrative findings mainly related to quality of the BDUA. These findings included multi-affiliation between regimes, pensioners unduly recorded in the BDUA, inaccurate SISBEN information in the BDUA; generating uncertainty about the quality and veracity of the information of the affiliates of the subsidized regime[32] , which affects the adequate aggregate amount of UPC done from ADRES to SGSSS. An improvement plan is currently being implemented by ADRES. The implementation of mitigation measures as detailed in the improvement plan will be followed up by the FM team and is part of the PAP.

10. Fraud and corruption remain an issue in the public sector and more specifically in the health sector. According to the 2018 Transparency International's Corruption Perception Index[33], Colombia was ranked 99 in the list of 180 countries analyzed. Actions supporting the GoC efforts to strengthen the SGSSS, are included in the PAP. Anti-Corruption is one of the pillars of the referred PND and there is a legal and operative framework to prevent fraud and corruption that should be implemented by all Government agencies, including MSPS and ADRES.

11. The CGR is responsible for issuing liability judgments when it finds that there was an irregular management of public resources. The CGR website reports that between 2013 and 2016, several cases of corruption occurred in Saludcoop and Cafesalud (EPSs) for a total amount close to USD 342 million. In 2019, the CGR evidenced new findings for USD 61 million in Saludcoop EPS related to medical services. This shows that the authorities are tackling fraud and corruption seriously. However, the persistence of these corruption cases explains that the fraud and corruption risk remain substantial.

1.3 Procurement

12. As referred in section C in Annex 3 of the PAD, the Program expenditure framework will support: (a) transfers to marginally finance a portion of current expenditures under SGSSS' health insurance (*aseguramiento en salud*) budget line, from the MHCP to ADRES. These transfers consist in a predetermined UPC, multiplied by the insured population duly documented in the BDUA; and (b) Personnel salaries to implement the proposed interventions. Consequently, no procurable items were identified within the Program expenditure framework and not specific Procurement arrangements are needed.

[32] The Subsidized Regime is the mechanism through which the poorest population, without payment capacity, has access to health services through a subsidy offered by the GoC.
[33] https://www.transparency.org/cpi2018

Section 2: Scope

13. The scope of the FSA is the UPC system at MSPS and ADRES and included the review of financial information and information obtained during working meetings with these entities directly responsible for the execution of the Program; as well as for the Program fiduciary management arrangements for the Program activities.

14. Other GoC entities were also involved and considered in the assessment due to their related responsibilities for the Program like the MHCP, the DNP, the CGR and the SNS. Additionally, to understand the functioning of the SGSSS, the assessment included a visit to a primary EPS "Salud Total EPS." Currently, there are approximately 44 public, private, and public/private EPS, which have legal, administrative and financial autonomy. The health system is financed by several mechanisms, through an insurance scheme based on UPC and payments for medical services rendered outside of the coverage of the UPC. For the provision of medical services, the EPSs, are required to count with an authorization from the SNS. Each EPS must guarantee the integrality, continuity and quality of the provision of health services included in the PBS, for which they must organize a network of IPSs. The relationship between the EPSs and the IPSs, is governed by private law, therefore, each EPS must prepare and maintain a hiring manual updated for its operation, with the application of limited competition, given the nature of the service. The EPS and IPS sign an agreement of wills (*Acuerdos de Voluntades*) and the main payment mechanisms applicable are regulated and are the following: (a) UPC; (b) payment per event; and (c) payment by case. The MSPS mission is to manage the health system and social protection in health, through policies for health promotion, prevention, treatment and rehabilitation of disease and insurance, as well as intersectoral coordination for the development of policies on determinants in health.

Section 3: Review of Public Financial Management Cycle

15. A Public Expenditure and Financial Accountability Assessment for Colombia was finalized in year 2016[34]; overall, Colombia's Public Financial Management system exhibits reasonable alignment with international best practices at the National Government level. The policy-based fiscal strategy and budgeting has particularly noteworthy positive performance on the institutional capacity to establish a credible fiscal strategy and comply with it. The same can be said of management of assets and liabilities; with room to strengthen the fiscal risk reporting.

3.1 Planning and Budgeting

16. Adequacy of budgets: According to the PEFA Colombia Assessment 2015 (carried out by the WBG in 2016) the budget is comprehensive, well documented, and implemented as planned, with actual expenditures deviating only slightly from planned levels. Budget planning is based on a multiyear perspective, and annual formulation reflects a mostly well-functioning policy-based system.[35] The Borrower has published its annual budget timely.[36] These considerations are applicate to the Program in MSPS and ADRES as well. The MSPS is part of the General National Budget and therefore subject to

[34] Public Expenditure and Financial Accountability Assessment (PEFA) 2015 of Colombia's Public Financial Management Systems, October 14, 2016.
[35] See PEFA 2015, IMF 2012 and the WBG reviews 2013 for more information.
[36] Decree 2467 of December 28, 2018.

budgetary controls, the budget of ADRES is composed of: (a) the contributions of the General Budget of the Nation defined through the budget section of the MSPS; (b) the assets transferred by the Nation and by other public entities of the national and subnational levels; (c) a percentage of up to 0.5 percent of the resources managed for its administrative expenses; and (d) the other income that at any title it receives**.**

17. The official projection with the breakdown of income and expenses in the ADRES budget structure will be consolidated at the end of October 2019, the date on which the preliminary draft (*anteproyecto*) must be formally submitted to the Superior Fiscal Policy Council (CONFIS)[37] once approved by the Board of Directors of the Entity.

3.2 Budget Execution

18. Program budget execution practices comply with international standards in Treasury Management and Internal Control Management. MSPS presents its budget following the budget calendar every year; including the budget line for the UPC that is accrued and transferred to ADRES monthly. ADRES as a decentralized entity execute its budget independently from MSPS and reports its budget execution in the same way.

19. The Program is being executed through the transfers from MSPS to ADRES to finance the insurance budgetary line and MSPS salaries. This insurance line is calculated based on the information from the BDUA for both the contributory and subsidized regimes. As stated by the *Punto Final* agreement, starting January 1st, 2020, ADRES on behalf of the EPSs will pay directly health services providers in accordance with the percentages and conditions defined by the MSPS.

Table A4-1. Initial Budget vs Actual Expenditure
(COP thousands)

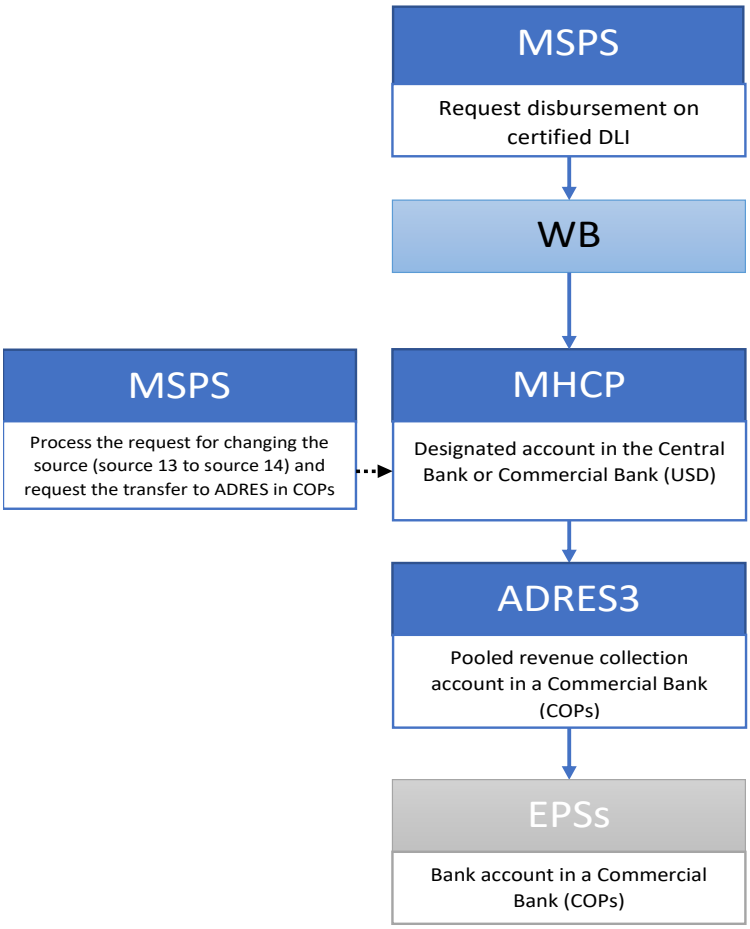
Fiscal Year	Initial Budget (A)	Actual Expenditure (B)	B/A %
2016	9,979,903	9,929,903	99.50
2017	10,098,821	10,898,821[38]	107.92
2018	12,188,014	12,155,014	99.73

Source: MSPS budget execution Nation's SIIF.

[37] The CONFIS is an agency attached to the MHCP, responsible for directing the Fiscal Policy and coordinating the Budget System. It is responsible for reviewing the National Investment Plan presented by the DNP and CONPES with the PND.
[38] COP 800 billion were added to the initial budget.

3.2.1 Flow of funds arrangements for Program implementation

20. The MHCP has requested to have special disbursement arrangements to support its budgetary controls that differs from the standard PforR policy:



(a) The General Treasury of the MHCP in coordination with the MSPS will open an USD account in the Central Bank or a commercial bank acceptable by the WBG under Treasury control, for the management of the funds disbursed by the WBG. This designated account arrangement has been requested by the GoC to the WBG and IDB with the objective of reinforcing ownership within the MSPS;
(b) The designated officials at the MSPS Treasury will be trained in the generation of the reports on Program execution and on the designated account by the SIIF Administration team at the MHCP;
(c) For the first year, the resources of the loan will be codified in the Nation's general budget as source 13 (foreign resources); once received the funds for DLIs achieved, the MSPS will begin the

process for changing the source (13 to 14), with a request to the MHCP that will authorize the change of source, and submit the request to the Budget Directorate where a Resolution would be issued approving the change of source. The total process could take about 20 days. After the first year MSPS will include a budget line on source 14 to execute WBG funding;
(d) Requests for disbursements to the WBG, will be made by MSPS following compliance with the DLIs. The MSPS will not request advances of resources for DLIs to the designated account;
(e) The MSPS will transfer the WBG funds in COP to ADRES, to a pooled revenue collection bank account. ADRES, in application of the regulations and as described in the 3.2 budget execution section, proceeds with the payments of the UPC, and other resources of the POS to the EPS. The current procedures for processing UPC in the ADRES are part of the POM.

3.2.2 Accounting and financial reporting

21. As per PEFA 2015, the consolidated public accounts, are prepared within six months after the end of the fiscal year. They include full information on revenues, expenditures, and financial assets and liabilities. Year-end accrual-based financial statements are issued by the Accountant General (CGN) and presented by May 15 of the following year to the CGR for audit purposes. The CGR auditing policies and procedures provide for the application of financial, compliance, and performance audits consistent with the International Standards of Supreme Audit Institutions (ISSAI). Audit reports are submitted before July 1 of the following fiscal year to the Congress and the President.

22. The MSPS prepares its financial statements under the CGN regulations. The Financial Statements of the Program are being generated through the GoC budgetary system (SIIF). They include the Statement of Accumulated Investments, Statement of cash flows and the Notes to the financial statements. These reports are being generated from the SIIF system with the support of the SIIF administration team. ADRES will submit to the WBG its institutional audited financial statements including program funds execution. The WBG will support capacity building for the MSPS/ADRES to enhance the financial reporting of program activities.

3.3 Internal Controls

3.3.1 Internal controls

23. According to PEFA 2015, the legal and regulatory internal control framework support a wide range of standards, including those of the Internal Control Act, the National System of Internal Control, and the Standard Internal Control Model (SICM), the last of which is based on standards of the Committee of Sponsoring Organizations of the Treadway Commission (COSO) and the Internal Control Guide of the International Organization of Supreme Audit Institutions (INTOSAI), which represent good international practices. Although the SICM was updated39 in 2014, and it refers in its technical manual to the principles of internal control from the COSO 2013 document, its consistency with international standards is partial. The Integrated Planning and Management Model (*Modelo Integrado de Planeación y Gestión*, MIPG) is addressing some of the inconsistencies.

[39] Decree 943 of 2014, whereby the SICM is updated.

3.3.2 Internal audit

24. GoC entities, including MSPS and ADRES, include an Office of Internal Control[40]. The head of the Internal Control Office Unit publishes every four (4) months on the entity's website, under disciplinary penalty, a detailed report of the state of internal control of the said entity[41]. Those from MSPS and ADRES are published periodically. In addition, MIPG is implemented, as stated by Decrees 1499 of 2017 and 1t299 of 2018. MIPG is considered as a framework of reference to direct, plan, execute, evaluate and control the management of public entities and organizations, to generate results that meet development plans and solve the needs and problems of citizens, with integrity and quality of service.

25. The head of the internal Control Office is also responsible for monitoring and reporting the general status of the internal control system, including the operation of the MIPG that is aligned with international standards. The Internal Control Offices at MSPS and ADRES carry out annual audit plans to comply with their mandate, and the reports are public. The Internal Control Offices are committed to perform internal audit for the Program.

3.3.3 Program governance and anticorruption arrangements

26. The Program will depend on the Government's framework for prevention and control of fraud and corruption. In Colombia an extensive legislation and regulations aimed at fighting corruption derive from the Political Constitution of 1991, which established the legal basis and control bodies for the control of entities that manage funds or assets of the Nation.

27. Corruption risk management is mandatory for all public entities since 2011, under the Anti-Corruption Statute established in Law 1474. In compliance with the Anti-Corruption Guidelines, the CGR will provide to the Bank periodically information on allegations of fraud and corruption, handling of said allegations, and final findings, all related to the Program and covering the MSPS, ADRES and EPS.

28. The SNS is the authority responsible for carrying out the inspection, surveillance and control of the constitutional and legal norms of the health sector and its resources. One of its most important functions focuses on inspecting and monitoring the SGSSS entities, as well as issuing instructions on how they must operate within the health system.

3.3.4 Complaints handling mechanism

29. The law states that any citizen can make their petition, complaint, claim, or suggestion through the PQRSD. Those allegations can be submitted by web (template forms of MSPS and/or ADRES), in person, through social networks or telephone.

[40] Law 1474 of 2011, article 9 related to the person responsible for internal control.

[41] MSPS: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/OCI/informe-pormenorizado-marzo-junio-2019.pdf;
ADRES:https://www.adres.gov.co/Portals/0/ADRES/Controlpercent20interno/PORMENORIZADOpercent20JULIOpercent202019.pdf?ver=2019-07-12-094810-463

30. Under this mechanism all PQRSDs are received. The Citizen Attention Group's main functions are to oversee, receive, register, and send virtual requests to the dependencies or entities that have the competence to answer them. Offices of Internal Control monitor and evaluate the management of the PQRSD that are presented to the MSPS and/or ADRES and prepare semiannual reports that are made public.

31. Main PQRSD topics reported in the MSPS management report as of May 2019, were related to Information systems (My Social Security); Human talent in health (Certifications on the professional exercise), medications and health technologies (Medication prices). The report also indicated the need to continue strengthening the strategies aimed at the timely and quality processing of the PQRSD.

Table A4-2. ADRES: PQRSD- Types of requests received June-December 2018

Type	Quantity of interactions with PQRSD system
Denounces	1
Complains on Personal data.	4
Requests of information	5
General interest requests	20
Request of information from National Congress	20
Appeals	67
Request for information	92
Consultation on ADRES database	339
Requests between authorities	1,383
Request of personal interest	16,369
ADRES non competency (transferred to another institution for processing)	230
Total	**18,530**

Source: ADRES, PQRSD Report July-December 2018.

32. The Program shall be subject to the WBG's Guidelines on Preventing and Combating Fraud and Corruption in Program-for-Results Financing, dated February 1, 2012 and revised July 10, 2015. CGR, under a Memorandum of Collaboration (MoC) agreement with the Bank will be reporting Fraud and Corruption cases affecting the per-capita insurance Program annually with their annual financial audit. Additionally, the Bank will monitor the public internal audit reports on PQRSD prepared by the MSPS and ADRES, on those issues related to fraud and corruption associated with the Program. Performance of the PQRSD system will be monitored throughout the project implementation.

3.4 Auditing

33. According to PEFA 2015, on average, 87.6 percent of the budget executed by the Central Government in the years 2012, 2013 and 2014 and 92.6 percent of aggregate assets were audited, the CGR used government auditing standards that were partially consistent with international standards. In

late 2018 a SAI PMF (Supreme Audit Institution Performance Measurement Framework)[42] was conducted to CGR and the conclusions include that the reduction of gaps is reflected in the results of the indicators evaluated; the achievements were reached with the support of higher authorities and CGR officials, through the implementation of the Strategic Plan (PE) 2014-2018, which incorporated a structured process of strengthening, based on an institutional performance model, aimed at develop skills and tools to fight corruption and support the public sector. As a result of the advances, there is a new fiscal control system aligned to the International Standards of Supreme Audit Institutions (ISSAI), characterized by the development of guides, formats and instructions for the three types of audit.

34. The CGR has been conducting annual financial audits of the MSPS; and ADRES; covering the Health Program transfers made by the MSPS to ADRES. CGR has also carried out a special audit of the BDUA covering the years of 2016 to 2018. CGR has audited the entities as programmed in its annual Audit and Fiscal Plans (PCVF). CGR and the Bank has agreed on a MoC that the annual audit program will continue to be carried out on an annual basis for both institutions involved MSPS and ADRES issuing the annual financial audit reports for each institution from the loan period of year 2020 until the closing of financing in year 2023.

35. The team has reviewed the last two years financial audits, and the special audit which included clean audit opinions for MSPS and qualified audit opinions for ADRES. The 2018 financial audit findings for ADRES are related to uncertainties in the accounts receivable to a liquidated health entity (ISS), and lack of timely legalization of advances for payments of services and technologies not funded from UPC resources; issues that started before ADRES was created, that are in process of resolution within the *Punto Final* agreement. The FM team will follow up the commitments of the executing entities in the implementation of the improvement plans submitted to CGR.

[42]https://www.contraloria.gov.co/documents/20181/449782/Informe+Final+MMD+EFS+CGR+Colombia+2019_unlocked.pdf/611096c8-6eef-4de0-924e-2839eab84552

Section 4: Program Systems and Capacity Improvements

Risk	Mitigation action	Timing	Type of action (PAP, DLI, etc.)
1. CGR may not deliver Financial audit for the program on annual basis.	(a) WB team will provide capacity enhancement support to the CGR to make sure audit program activities at MSPS/ADRES are carried out during the financing period; (b) Confirmation from CGR by the MoC on: i) issuance of external financial audit to the program during the financing period; including the schedule for the audit in its Annual Audit Plan to be carried out during the first semester of the year so that the audit report could be submitted to the WBG by July 31, of each year; and ii) The Comptroller shall participate in periodic discussions with the Bank regarding the results of the Program financial statement audits; (c) MHCP will follow up with CGR on the annual financial audit for the Program and will follow up with the WBG team.	Semi-Annually One month after effectiveness Annually	Implementation Support PAP
2. Program's annual Financial reports may not be delivered to the WBG.	WBG team will provide capacity building for the MSPS/ADRES to enhance the financial reporting of program activities.	Semi-Annually	Implementation Support
3. Adequate internal controls may not be implemented during the Payment processes.	FM team will follow up on: (a) the implementation of actions to address the improvement plans presented by MSPS/ADRES to CGR; and (b) measures included in the Punto Final Agreement.	Semi-Annually Annually	PAP
4. Adequate reclassification from source 13 to source 14 may not be approved by MHCP for the first year.	MHCP should confirm on the approval of reclassification of Budgeted sources on a timely basis.	June 2020	PAP

5. Adequate budget allocation for Program execution could be reduced due to budget space.	MSPS should confirm the proposed budget allocation for the Program budget line.	Annually	Implementation Support
6. Information on Fraud and Corruption, and Complaints handling for the Program may not be reported/ provided to the WBG.	The Comptroller shall provide to the Bank information on allegations of fraud and corruption, handling of said allegations, and final findings, all related to the Program and covering the MSPS, ADRES and each EPS.	Annually	PAP and Implementation Support
7. Weaknesses in the BDUA related to the quality and timely maintenance may increase.	Submit to the Bank the status of the improvement plans presented semi-annually to the CGR on the results of the special audit performance report carried out to the BDUA in ADRES in year 2019, and of any other subsequent audit that could be carried out to the BDUA.	Semi-Annually	PAP

Section 5: Implementation Support

36. The fiduciary team will work with the MSPS/ADRES to monitor implementation progress and address underperforming areas identified in the PAP. Fiduciary support includes:

- Helping the borrower resolve implementation issues and carry out institutional capacity building.
- Monitoring the performance of fiduciary systems and audit reports, including the implementation of the PAP.
- Monitoring changes in fiduciary risks to the Program and, as relevant, compliance with the fiduciary provisions of legal covenants.

ANNEX 5. SUMMARY ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT

1. An Environmental and Social Systems Assessment (ESSA) to the "Improving Quality of Health Care Services and Efficiency in Colombia" (the Program) was carried out according to the WBG's Operating Policy 9.00. The specific objectives of the ESSA include: (a) identify the possible benefits, risks and environmental and social impacts applicable to the interventions of the Program; (b) review the policy and legal framework related to the management of the environmental and social impacts of Program interventions; (c) assess the institutional capability regarding environmental and social management systems within the Program system; (d) assess the performance of the Program system with respect to the basic principles of the PforR instrument and identify gaps, if any; and (e) submit recommendations and PAPs to address gaps and improve performance during the program's implementation.

2. Regarding the environmental component, the ESSA approach focuses on the management of HCW generated by IPSs. The WHO points out that the waste generated by the activities of health facilities, from contaminated needles, sharps, chemical, cytotoxic and radioactive waste, has a higher potential risk of producing wounds and infections than any other type of waste and its improper handling can cause serious public health consequences and considerable impact on the environment.

3. From the Social point of view, the ESSA assesses management capacity linked to distributive equity, affordability and cultural or gender limitations to access or participate in the Program. Furthermore, the assessment is made on the structure of the agencies involved, regarding disclosure measures, consultation mechanisms, jurisdictional or geographical diversity, cultural, financial or physical barriers that hinder the participation of socially marginalized or disadvantaged groups (for example, the poor, the disabled, children, the elderly, indigenous peoples or religious or ethnic minorities). The risks of creating or exacerbating a social conflict are also considered, especially in fragile states or situations e.g. migrants, ethnic groups and remote or isolated populations.

4. The relevance of the ESSA's core principles in relationship to the Program interventions has been assessed by the team and summarized in Table 5 (Main Text). Among the ESSA's six basic principles, four are considered as relevant to the Program. In terms of environmental issues: Core Principle 1 - General Principle of Environmental and Social Management is relevant to the program activities and Core Principle 3 - Protect public and worker safety against the associated potential risks. In terms of social issues: Core Principle 5 - Due consideration to be given to the needs or concerns of vulnerable groups and Core Principle 6 - Avoid exacerbating social conflicts. Core Principe 2 - Impacts on natural habitats and physical cultural resources and Core Principle 4 - Land Acquisition, are not pertinent in this case since there is no land acquisition and therefore no impact on private assets or livelihoods are expected; the activities supported by the Program won't have any impact on natural habitats nor cultural resources.

5. The ESSA confirms that the current systems of the GoC to manage the environmental and social aspects of the Program have a solid basis in a robust legal framework to provide equitable and inclusive access to EPS; and in a decentralized management system, with autonomy of its territorial, democratic, participatory and pluralistic entities established at the constitutional level. There are also long-standing institutional mechanisms based on the PND and the documents of the CONPES so that several

stakeholders have participation spaces regarding the Health System, including procedures for Petitions, Complaints, Claims, and Suggestions at the national and local levels.

6. The combined risk assessed at entry is low; the ESSA confirms that the current system for managing the environmental aspects of the Program are reasonably covered by the regulations and institutional capacity of the entities involved, where the MSPS establishes the policies and the decentralized authorities carrying out actions of IVCS. The findings from this ESSA are intended to ensure that this Program is implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes or mitigates adverse environmental and social impacts and risks. The PAP includes activities that would bridge the remaining gap in the environmental and social management systems in line with the six core sustainability principles of the PforR.

Environmental System and Climate Screening

7. The Environmental risk was considered "Low," as the Program will not generate a significant increase in medical waste compared to the current situation, as the amount of IPSs is not increased, nor is a substantial increase expected in the number of enrollees given its already high number. However, the possible (minor) increases in the generation of HCW may be due to improvements in the quality of benefits, and early diagnosis and treatment of diseases such as cancer or diabetes, during early stages (until such medical practices are usual in the universe of benefits). The operational phase may exhibit certain risks and impacts associated with the management of medical waste and other solid and liquid waste within health facilities (segregation or selective collection by category, packaging and temporary storage), the transportation, treatment and final disposal of solid medical waste, with special attention to hazardous waste. If not managed well, these activities will pose a threat to the environment, public health and safety at work. The institutional configuration has the potential to develop the capacity required to deal with the potential environmental risks and challenges. Dispersed populations have disadvantages for the final treatment of HCW and waste from electrical and electronic equipment (WEEE), related to the lack of economic attractiveness of providers of said service linked to the low volumes generated.

8. The ESSA confirms that the current system for managing the environmental aspects of the Program is reasonably covered by the regulations and institutional capabilities. The management of HCW has two instances, one within the health facilities (intramural), under the monitoring of the MSPS, and another outside the IPS (extramural), under the supervision of the MADS. Decree 351 of 2014[43] regulates from an environmental and health standpoint the integral management of waste generated in health care and other activities. At the sub-national levels, the departmental, district and local health authorities are responsible for the IVCS for the management of intramural RES. At an extramural level, the external management of the HCW is under the purview of the regional environmental authorities (Regional Autonomous Corporations, Corporations for Sustainable Development, and Urban Environmental Authorities) in accordance with the legal provisions and policies of the MADS. The provisions in the existing environmental legal and regulatory framework are adequate and require an enabling institutional and technical capability to comply with these. Law 1672 of 2013 and Decree 284 of 2018 establish the Public Policy for the integral management of WEEEs. The destinations considered for the WEEEs are: (a) a

[43] Compiled in Decree 780 of 2016 - Single Regulatory Decree of the Health Sector.

post-consumption program with eight streams lacking economic costs (recovery) and (b) delivery to an authorized waste manager.

9. The findings of the ESSA identified a general level of implementation and satisfactory compliance with current standards for the handling of medical waste, being further able to verify the structure and content of reports from the Registry of Generators of Waste or Hazardous Waste[44] (*Registro de Generadores de Residuos o Desechos Peligrosos*, RESPEL). The RESPEL becomes a management instrument for the Deputy Directorate of Environmental Health (*Subdirección de Salud Ambiental*, SSA) of the MSPS, the MADS, and the Institute of Hydrology, Meteorology and Environmental Studies (*Instituto de Hidrología, Meteorología y Estudios Ambientales*, IDEAM) from the records generated at the IPS level. The information collected in the RESPEL (annual) report is prepared for the year ended, a situation that conditions timely decision-making if changes in the patterns of generation of HCW (quantities, types) occur. In this manner, the information for a modification of policies, needs for inputs and resources, could be late in the face of trends in general increases in the HCW or of a particular waste stream that would demand a timely or specific treatment.

10. To maximize the benefits of the Program, the ESSA recommends: (a) Maintain continuous training efforts in the handling of RES, in addition to the inclusion of modules on HCW management in the training of human talent; (b) Monitor the result of the IVCS actions under the purview of local authorities. At present, the reporting level is annual for the year ended, which makes it difficult to make informed decisions for the preparation of public policies (that anticipate and avoid risks and HCW impacts, and when it is not possible to avoid them, they can minimize them or reduce them to acceptable levels). Recommend moving towards a more limited time report, or partial reports which the SSA can access; (c) Promote access to information on HCW flows that allow the display of disaggregated data making it available to the SSA for the sub-categories: Y1.1 (pathogenic waste), Y1.2 (bio sanitary waste), Y1.3 (sharp product waste); and Y1.4 (animal waste) in timely fashion; and (d) Continue with the implementation of the national and regional dissemination and awareness-building plan for WEEEs that is provided in Decree 284 of 2018.

11. The “Guidelines for the Formulation of Plans for Adaptation to Climate Change, from the Environmental Health Component” were proposed by the SSA of the MSPS in 2016.

12. The main health impacts expected as a result of Climate Change are linked to the fact that 85 percent of the Colombian territory has ecological, climatic and epidemiological characteristics conducive to the transmission of malaria. A two-degree increase in temperature (from 24 ° C to 26 ° C) more than double the number of infectious mosquitoes, which means that temperature and precipitation variations are linked with an increase in the incidence of diseases transmitted by malaria and dengue fever vectors. The increase in the minimum nighttime temperatures in the foothills of the Andes and with changes in the hydrological cycle induced by the phenomenon of the *El Niño*-Southern Oscillation (ENSO) favor the development of vectors. Approximately 23 million Colombians live in areas of endemic dengue and and 13 million in areas of malaria transmission.

[44] It is integrated from standardized, homogeneous and systematic information on the generation and handling of waste and hazardous waste originating from the country's various productive and sector activities.

13. Climate and disaster risk screening conducted for the Program confirmed that the risk of exposure to climate change is Moderate**.** Program activities could be affected by extreme precipitation and flooding, disturbing the access to facilities, damaging the health service infrastructure, and increasing the incidence of vector-borne diseases such as malaria and dengue. Recent work reported under the INAP points to a gradual trend in Colombia of exposure to tropical vector diseases (malaria, in particular).

14. Climate adaptation and mitigation measures supported by the Program. Through its Results Areas, the Program seeks to improve the quality of health services as well as promote a more efficient system, including for uninsured populations (such as migrants). These would be critical in managing the health care delivery response to diseases exacerbated by the effects of climate change. DLI1 will incorporate the approval of the new resolution for certification of IPSs, including new requirements to comply with standards for climate change adaptation and disaster response, to prevent or reduce the effects of climate change on health facilities. These adaptation guidelines and standards will include specific measures to ensure facilities are able to deal with extreme heat events through effective insulation and shading, are equipped to respond to wildfires with axes, fire beaters as well as having ambulatory vehicles able to deal with these threats. Through DLI1, the Program will support the approval of new parameters for IPS and EPS accreditation, including new requirements for construction, infrastructure, environmental and energy saving, among others. For example, where necessary facilities will be renovated or even relocated to reduce flood risk either from sea level rise, in coastal areas, as well as from flash and/or river flooding in inland and mountainous areas.

15. The Program will implement further adaptation solutions to the climate challenge**.** As indicated by the Program intermediate indicators (“Number of health care professionals trained in continuous quality improvement”, and “Interoperability standards developed and implemented”), the PforR will contribute to climate adaptation as health workers will be educated on climate impacts and disaster response firstly by including climate adaptation topics in medical and nursing school curricula (as well as other health professional training protocols) and secondly by including these topics in CME curricula. The establishment of the interoperable health data system will ensure the availability of additional epidemiological data for public health surveillance and response facilitating the early detection of climate sensitive communicable diseases (particularly vector-borne diseases such as malaria, and dengue) but also help pick up epidemiological shifts in less well recognized climate related health impacts, for example those related to NCDs and extreme heat or poor air quality (due to windborne dust) or nutrition-related issues.

16. The Program will implement mitigation solutions to the climate challenge through the following activities. Through the DLI1 requirements for construction, infrastructure, environmental and energy saving, there are important opportunities to mitigate greenhouse gas emissions from the health sector. The DLI will require full energy audits of large health facilities as well as simpler walk through audits for smaller facilities. Tree planting on health sector land will contribute to carbon sequestration, as well as providing important adaptation benefits through shading (providing heat protection) and reducing flood risk in extreme precipitation. Mitigation topics in medical and nursing school curricula (as well as other health professional training protocols) in CME will be delivered alongside the adaptation components mentioned above.

Social System

17. The social risk was cataloged as "Low" because there is a diagnosis based on participatory consensus and mechanisms to address health-related social demands. The Program additionally has a low probability of any negative social impact given that it includes the inclusion of indigenous peoples, ethnic minorities and other vulnerable communities linked to dispersed rural populations, the victims of the armed conflict and returning Venezuelan and Colombian migrants. As no construction is planned, no expropriations or resettlements will be carried out.

18. The MSPS provides leadership in the formulation of the PPSS, which aims to guarantee the right of citizens to be engaged in the sector's decision-making process that affects or is of interest them, in compliance with the Statutory Health Law. There are also specific frameworks to reduce inequities that affect vulnerable populations: ethnic groups and native peoples, as well as other vulnerable groups, have spaces for consultation such as "workgroups" and "protocols" for socio-cultural adaptation and inclusion of intercultural approaches, spaces for agreements and establishment of standards of care that respect their ethnic and cultural identity, forms of social organization and linguistic characteristics. However, the SISPI, and the guidelines with directives and guidance for the socio-cultural adaptation and inclusion of the intercultural approach for indigenous, Afro-Colombian, Raizales, Palenquero and the Rom peoples' communities are still in preparation.

19. Indigenous people have less favorable indicators in terms of morbidity and mortality than the rest of the population. The infant mortality rate in all ethnic groups (mainly Rom and *Palenqueros*) is higher than in the national total and in the rest of the population, with rates equal to more than three times the national rate. For its part, in the case of maternal mortality, the indicator for indigenous, black and Afro-Colombian groups is equal to more than three times the indicator for the national total and about four times higher in relation to the rest of the population.

20. There are also two specific cases that require consideration in Colombia, the first one is related to the psychosocial impacts and damage to the physical and mental health of the victims caused by or in relation to the country's internal armed conflict. The second is related to the migration of Venezuelans residing in or in transit through their territory (due to the difficult economic, political and social situation of their country), and returning Colombians who had emigrated due to the armed conflict.

21. Colombia has suffered for decades an internal armed conflict, which in addition to the direct consequences in its territories and to its inhabitants, has been the origin of an exodus of citizens to other countries. For the past six years the GoC has established the PAPSIVI that provides coverage for these problems through insurance in the health system, although without achieving full coverage in its first stage.

22. In the case of migrants (approximately 1.63 million Venezuelans), different strategies address their care, depending on whether their status is linked to the PEP or Boder Mobility Card (*Tarjeta de Mobilidad Fronteriza*, TMF), among other mechanisms which include vaccination systems for children, birth delivery, initial emergency care, etc. However, there are still difficulties caused by the migrants' own irregularities (illegal entry, stays beyond time allowed), as well as by not being able to enroll in the subsidized health regime for not complying with the requirements set forth by the SISBEN.

23. The Program has a low probability of any negative social impact and will mitigate several of these risks, based the Program's quality improvement interventions: (a) certification of medical care providers; (b) accreditation of medical care providers; (c) mandatory quality indicators; (d) quality improvement plans for medical care providers; (e) enhancing human resources for health and (f) citizen participation.

24. To maximize the benefits of the Program, ESSA recommends that: (a) Continue with the mechanisms of broad participation of actors and social representatives of the sector, so that the SGSSS has the required legitimacy; (b) Proactively continue with the development of the inclusion tables and protocols provided in the CONPES for ethnic groups. Which implies the conclusion of the guidelines, directives and guidance for the socio-cultural adaptation and inclusion of the intercultural approach. These instruments consider standards of care that respect the ethnic and cultural identity, forms of social organization and linguistic characteristics for each ethnic group; (c) Move forward for the purpose of completing the SISPI. Especially complete Stage II (Preparation of the Base Document, and validation of the 5th component) and Stage III (administrative act of the MSPS and submission to the Permanent Coordination Workgroup). A documented record of the participation of stakeholders shall be established, which will include a description of the stakeholders consulted, a summary of the opinions received and a brief explanation of how the opinions were taken into account, or the reasons why this didn't happen; and (d) Establish mechanisms to identify migrants that allow the implementation of insurance mechanisms, to contribute to the improvement of their health and to the protection of Colombian public health. This is made effective by means of a census list or equivalent instrument coordinated by the MSPS Department for Regulation of the Operation of Health Insurance, Occupational Risks and Pensions.

ANNEX 6. PROGRAM ACTION PLAN

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement
Implementation of actions to address the improvement plans presented by MSPS/ADRES to CGR; and measures included in the Punto Final Agreement.	Fiduciary Systems		MSPS and ADRES	Recurrent	Semi-Annually	Agreed actions to address the improvement plans presented to CGR, implemented (Semi-Annualy); and follow up measures included in the Punto Final Agreement reported (Annually).
MHCP should confirm on the approval of reclassification of budgeted sources on a timely basis.	Fiduciary Systems		MHCP	Other	After effectiveness	For the first year of Program effectiveness, budgeted sources allocation process confirmed by MHCP.
CGR will provide to the Bank information on allegations of fraud and corruption, handling of said allegations, and final findings, all related to the Program and covering the MSPS, ADRES and each EPS.	Fiduciary Systems		CGR	Recurrent	Yearly	Information on Fraud and Corruption, and complaints handling, sent to the WBG.
CGR will deliver the Program's Annual Financial Audit on time, as agreed on the MoC	Fiduciary Systems		CGR	Recurrent	Yearly	MHCP will follow up with CGR on the annual financial audit for the Program, and will follow up with the WBG team.
HCW: 1) Monitoring plans of health facilities, developed. 2) Statistical information of waste streams, implemented on selected facilities. 3) Updating the	Environmental and Social Systems		Directorate of Environm. Health (MSPS)	Recurrent	Yearly	1) Audit reports. 2) Statistical information of waste streams in their categories, discriminating waste streams of Y1 in subcategories, implemented by the Environmental Authorities, on selected IPSs. 3) Information loaded annually into the RESPEL.

RESPEL system annually.						
Treatment and final disposition of HCW: 1) Discriminate waste streams in subcategories, through a function of the RESPEL (1: pathological waste, 2: bio sanitary waste, 3: sharps waste, animal waste) 2) Communication 3&4) Analysis and Reports.	Environmental and Social Systems		MADS/Directorate of Environmental Health	Other	1) & 2) After effectiveness/ 3) One year after effectiveness/ 4) Two years after effectiveness	1) Minutes of the agreement for accessing to the functionality in the Registry of Hazardous Waste Generators for each of the sub-categories by the SSA, signed. 2) Communication and awareness. 3&4) Analysis and Implementation Report.
SISPI Implement process of stakeholder participation to advance in: 1) Stage II (Preparation of the Document, and validation of the 5th component) 2) Stage III (Issue a MSPS Admin. Act for the approval of the Permanent Conciliation Table).	Environmental and Social Systems		MSPS Department of Social Promotion	Other	Stage II (Six months after effectiveness) Stage III (One year after effectiveness)	1) Document prepared 2) Document approved.
For Afro-Colombian, Raizales and Palenqueras communities and the Rom people: Implement the process of stakeholder participation to advance in the pending stages to reach the guidelines for a socio-cultural adaptation of the intercultural	Environmental and Social Systems		MSPS Department of Social Promotion	Other	One year after effectiveness	Consultation process with the interested parties, for the construction of technical guidelines of deferential approach for black Afro-Colombian, Raizales and Palenqueras communities, dully documented.

approach.						
Submit the status of the improvement plan presented to the CGR on the special audit carried out to the BDUA in ADRES in year 2019, and of any other subsequent audit that could be carried out to the BDUA.	Fiduciary Systems		MSPS and ADRES	Recurrent	Semi-Annually	Status of the improvement plan submitted to the WBG.
Capacity building in the process of collecting the data for reporting financial execution and DLIs.	Technical		MHCP/DNP/MSPS	Recurrent	Semi-Annually	DLIs reports acceptable to the WBG, submitted in a timely manner.

ANNEX 7. IMPLEMENTATION SUPPORT PLAN

1. **The Implementation Support Plan is in line with the WBG's PforR operational guidelines.** The Borrower is responsible for the implementation of all Program activities in support of achievement of the agreed DLIs, as well as of resolution of bottlenecks identified in the fiduciary and environment and social assessments. The WBG will tailor implementation support in technical, fiduciary, environmental and social aspects to ensure the following:
   (a) Review the Program implementation progress, and achievement of Program results, monitor and help the Borrower as needed with institutional capacity building and implementation issues;
   (b) Provide technical advice to the implementation the activities under the results areas as needed, the achievement of DLIs and the implementation of the PAP;
   (c) Advise and review documentation prior to serving as evidence for the fulfillment of DLIs as may be appropriate (e.g. certification and accreditation manuals);
   (d) Monitor compliance with legal agreements, keep records of risks and propose remedy actions to improve Program performance, if and as needed;
   (e) Provide support in resolving any operational issues pertaining to the Program;
   (f) Monitor the performance of fiduciary systems, potential changes in fiduciary risks of the Program; Monitor the Program financial statement preparation process and assist the Borrower as necessary; and
   (g) Review the Program annual financial audit report and discuss with the Borrower and monitor the implementation of the auditor's recommendation; and based on the information provided by the audit reports, assess and analyze changes in fiduciary performance of the Program and propose remedial actions, as needed.

2. **The following major categories of support are envisioned:**
   (a) Implementation support and capacity building relating to the result areas and DLIs that require technical assistance and support from WBG staff and consultants, as well as global partners such as PHCPI. Examples include: (i) the updating of the SOGC, and the capacity building for the health sector workers in continuous quality improvement (both related with DLI 1); (ii) technical assistance for reviewing the risk-adjustment methodology and proposing recommendations for adjustments to the UPC (DLI 3); and (iii) capacity building and sensibilization of health workers in receiving areas on issues related to migrants' health, and training on migrants' protocols and guidelines to ensure that qualifying migrants can exercise their health care coverage rights. (related with DLI 4); and
   (b) Supervision of operation, technical and fiduciary review: supervision will be conducted on a regular basis.

Table A7-1. Main focus of Implementation Support

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	1. Program Operations Manual 2. Result and Monitoring Reports 3. Financial Reports 4. Documentation for submission of DLI's evidence according verification protocols 5. TA for the initial milestones of DLIs 6. Fiduciary 7. Environmental and social	1. Operations and implementation support 2. M&E 3. Health economics 4. Health information systems 5. Quality of care and service delivery 6. Fiduciary 7. Environmental and social	Four visits of the core team TA support as needed by specialty areas	TA Financing support Experts from partners participating in relevant visits
12-48 months	1. Program operation and process 2. Monitoring and evaluation 3. Health information system and big data 4. Documentation for submission of DLI's evidence according verification protocols 5. TA for the annual DLIs milestones and for implementing the activities under each result area 6. Fiduciary 7. Environmental and social	1. Operations and Implementation support 2. M&E, Health economics 3. Health information systems, data engineer 4. Quality of care and service delivery 6.Fiduciary 7. Environmental and social	Two regular supervision visits TA support as needed by specialty areas	TA Financing support Experts from partners participating in relevant visits
Other				

Table A7-2. Task Team Skills Mix Requirements for Implementation Support (per year)

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Senior Economist (co-TTL)	10	4-5	Headquarters-based
Senior Health Specialist (co-TTL)	10	4-5	Country-based
Senior Operation Officer	8	2-4	Country-based
Health Economist	8	2-4	Headquarters-based
FM Specialist	5	2	Country-based
Environmental and Social Specialist	3	2	Country-based
Technical Consultants	As required	As required	International and country-based

Table A7-3. Role of Partners in Program Implementation

Name	Institution/Country	Role
Primary Health Care Performance Initiative (PHCPI)		TA in quality of care and service delivery (DLI1 and 2)
UnitedHealth Group		Methodological assessment and revision of the UPC (through an EFO) (DLI 3)
Institute for Health care Improvement (IHI)		TA in quality of care and capacity building in continuous quality improvement (DLI1)
Access Accelerated		TA in pharmaceutical policies (DLI3)
SaluDerecho		TA in issues related to the judicialization of health
International Organization for Migration (IOM)		TA in capacity building for affiliation of migrants with PEP to SGSSS (DLI4)
UNHCR		TA in capacity building for affiliation of migrants with PEP to SGSSS (DLI4)

State and Peacebuilding Fund (SPF)	TA for training and other capacity building to strengthen the sector's ability to address some of the challenges related to the Venezuelan migration (DLI 4)