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COLOMBIA

SUPPORT PROGRAM FOR REFORM OF THE GENERAL SOCIAL SECURITY HEALTH CARE SYSTEM II

(CO-L1141)

LOAN PROPOSAL

This document was prepared by the project team consisting of Ana Lucía Muñoz (SPH/CCO), Project Team Leader; Ursula Giedion (SPH/CCO); Carolina González (SCL/SPH); Frederico Guanais (SCL/SPH); Francesca Castellani (CAN/CCO); Mónica Lugo (LEG/SGO); Bibiana Taboada (SPD/SDV); and Sheyla Silveira (SCL/SPH), who helped to produce this document.

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REQUIRED

1. Policy Letter
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38893263
2. Means of Verification Matrix
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38279254
3. Results Matrix
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38281242

OPTIONAL

1. Economic Analysis
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38315389
2. Monitoring and Evaluation Arrangements
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38281255
3. Comparison Matrix
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38578620
4. Safeguard Policy Filter Report
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38281388
5. Bibliographic References
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=38279106

ABBREVIATIONS

CONPES	Consejo Nacional de Política Económica y Social [National Economic and Social Policy Council]
CPU	Capitation payment unit
DNP	Departamento Nacional de Planeación [National Planning Department]
FOSYGA	Fondo de Solidaridad y Garantía [Solidarity and Guarantee Fund]
IETS	Instituto de Evaluación de Tecnologías Sanitarias [Institute for the Evaluation of Health-related Technologies]
ISC	Inspection, surveillance, and control
LIBOR	London Interbank Offered Rate
MHCP	Ministry of Finance and Public Credit
MINSALUD	Ministry of Health and Social Protection
NCG	National central government
OECD	Organization of Economic Co-operation and Development
PBP	Programmatic policy-based loan
POS	Plan Obligatorio de Salud [Mandatory Health Plan]
SGSSS	Sistema General de Seguridad Social en Salud [General Social Security Health Care System]
SISMED	Sistema de Información de Precios de Medicamentos [Medication Price Information System]
SNS	Superintendencia Nacional de Salud [National Superintendency of Health]

PROJECT SUMMARY

COLOMBIA
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<table>
<tr><th colspan="4">Financial Terms and Conditions</th></tr>
<tr><td colspan="2" rowspan="2">Borrower: Republic of Colombia
Executing agency: Ministry of Finance and Public Credit (MHCP), in technical coordination with the National Planning Department (DNP)</td><td colspan="2">Flexible Financing Facility*</td></tr>
<tr><td>Amortization period:</td><td>Bullet payment on 15 July 2027</td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>Original WAL:</td><td>12.75 years**</td></tr>
<tr><td>IDB (Ordinary Capital)</td><td>400 million</td><td>Disbursement period:</td><td>1 year</td></tr>
<tr><td>Local</td><td>0</td><td>Grace period:</td><td>12.75 years**</td></tr>
<tr><td>Total</td><td>400 million</td><td>Interest rate:</td><td>LIBOR-based</td></tr>
<tr><td colspan="2" rowspan="2"></td><td>Inspection and supervision fee:</td><td>***</td></tr>
<tr><td>Credit fee:</td><td>***</td></tr>
<tr><td colspan="2"></td><td>Currency:</td><td>U.S. dollars from the Bank’s Ordinary Capital</td></tr>
<tr><th colspan="4">Project at a Glance</th></tr>
<tr><td colspan="4">Program objective: This is the second and final operation in a series to support reform of Colombia’s General Social Security Health Care System (SGSSS), using a programmatic policy-based loan. The objective of this programmatic series is to assist in designing and implementing reforms to the system, as a means of generating ongoing improvement in health care outcomes, enhancing financial protection for users of the system, and ensuring the system’s long-term financial sustainability. The new reforms are expected to strengthen the health care system, by establishing a service delivery model that will improve health care outcomes, promote management of the risk of disease through preventive care, establish equitable access to high-quality services, enhance efficiency in managing resources, promote the rational and equitable use of health-related technologies, and provide for a higher degree of inspection, surveillance, and control in the health sector.</td></tr>
<tr><td colspan="4">Special contractual conditions: The disbursement of resources is subject to fulfillment of the policy reform measures detailed in the description of the program’s components (paragraphs 1.32 to 1.43 and Annex II), along with fulfillment of the other conditions established in the loan contract.</td></tr>
<tr><td colspan="4">Exceptions to Bank policies: None.</td></tr>
<tr><td colspan="4">Project qualifies as: SEQ [X] PTI [X] Sector [X] Geographic [ ] Headcount [ ]</td></tr>
</table>

* Under the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule, and currency and interest rate conversions, subject in all cases to the final amortization date and original weighted average life of the project. When considering such requests, the Bank will take market conditions into account, along with operational and risk-management considerations.

** The weighted average life (WAL) and grace period may be shorter depending on the date the loan contract is actually signed.

*** The credit fee and the inspection and supervision fee will be established periodically by the Board of Executive Directors, as part of its review of the Bank’s lending charges, in accordance with applicable Bank policies.

I. DESCRIPTION AND RESULTS MONITORING

A. Colombia's recent macroeconomic performance and financing needs

1.1 Colombia's economy has performed well in recent years. Gross domestic product (GDP) was 6.6% in 2011 and 4% in 2012. In the third quarter of 2013, the Colombian economy increased 5.1% over the same quarter of 2012. Taking into account January through September of 2013, GDP grew by 3.9% over the same period in 2012. During this period, the greatest growth was in the following areas: 10.8% in construction; 6.1% in the agriculture, forestry, hunting and fishing sector; and 4.8% in social, community, and personal services. At the same time, manufacturing decreased by 1.2%. On the demand side, in 2013 (January-September), GDP growth was associated with a 4.3% increase in final consumption, 3.4% growth in gross capital formation, and a 2.4% increase in exports, all compared to the same period of 2012. For 2013, the government continues to project growth of 4.5%, while the Central Bank (Banco de la República) is predicting an increase of 3% to 4.5%. According to the latest BVC-Fedesarrollo Financial Opinion survey, analysts' expectations put the growth figure at 3.9%.

1.2 In 2012, the nonfinancial public sector (NFPS) had a surplus amounting to 0.4% of GDP, while the national central government (NCG) had a deficit of 2.4% of GDP. Tax receipts, which grew by 14%, went from Col$94.2 trillion in December 2011 to Col$107 trillion in December 2012. In the same period, expenditures increased from Col$106.6 trillion to Col$119 trillion. Spending on interest continued to represent a major category of public outlays, accounting for 2.6% of GDP. For 2013, a NCG fiscal deficit similar to that of 2012 is forecast. This deficit projection took into account the effects of the tax reform in late 2012, which was expected to be revenue-neutral for 2013-2014, but will take effect at the end of fiscal year 2013.

1.3 In 2014, the nation's total financing needs are expected to reach Col$39.813 trillion (5.6% of GDP). As sources of financing, the NCG can draw on resources including disbursements of domestic and foreign debt, amounting to Col$39.879 trillion (5.2% of GDP). External financing sources are expected to total US$5 billion (1.2% of GDP), of which US$2 billion (0.5% of GDP) is from multilateral organizations, with US$3 billion from the placement of bonds in the external market. The present operation contributes US$2 billion in multilateral financing, amounting to 20% of total financing in that category.

1.4 The balance of payments projection for 2013 called for a current account deficit of 3.0% to 3.6% of GDP, consistent with results from recent years. This would be financed with surpluses in the capital and financial accounts, mostly from foreign direct investment (FDI).

1.5 In 2013, inflation was 2%, down from 3.5% in 2012, while the exchange rate remained volatile. There was a nominal appreciation in the peso of 9% in 2012,

with a nominal depreciation of 9% in 2013. Since the beginning of 2014, the peso has already depreciated by 6%.

1.6 The country's positive economic performance, combined with a consolidation of fiscal accounts and meeting of inflation targets, has filtered down to the labor market, where unemployment was in the single digits (9.6%) at the end of 2013. As a result of these factors, there has been a decline in poverty rates, from 49% in 2002 to 32.7% in 2012, along with a reduction in the rate of indigence, from 18% in 2002 to 10.4% in 2012. The Gini coefficient, though it has declined, remains high, at 53.9.

B. Frame of reference, problem to be addressed, and rationale

1.7 **Colombia's health care system.** With the passage of Law 100, in 1993, Colombia transformed its National Health System from a wholly public system to an insurance-based scheme, involving both insurers and public and private providers, known collectively as the General Social Security Health Care System (SGSSS). The insurers, known as Health Promotion Enterprises, compete for members and for managing the population's health insurance. They are also responsible for collecting contributions from the members and for contracting and paying for the health care services network, which may include public and/or private providers. The service providers, known as Service Provider Institutions, compete to sell health care services to the Health Promotion Enterprises. Each Health Promotion Enterprise receives a per-person premium—the so-called capitation payment unit (CPU)—used to cover the benefits plan, known as the Mandatory Health Plan (POS), to which all users of the SGSSS are entitled. Both the POS and the CPU are designed to be updated periodically.

1.8 The SGSSS is divided into two categories: the Contribution-based Regime and the Subsidized Regime, each with distinct target populations and sources of financing. The Contribution-based Regime serves employees in the formal sector, as well as retirees and independent workers, with financing provided by the members, or, in the case of formal workers, by a shared employer/employee contribution. The Subsidized Regime serves populations who lack the economic ability to pay, and is financed by a combination of funds from the nation's general tax revenues, funding directly from the departments and municipios (royalties from mining; taxes on gaming, cigarettes and liquor), and cross-subsidies from the Contribution-based Regime. For the Subsidized Regime, the national government transfers the per-member CPU amount to the territorial entities (departments and certified municipios).

1.9 The State delegated to the Health Promotion Enterprises the functions of membership and collecting fees that members pay to the Contribution-based Regime. They collect fee-based contributions, subtract from the fees the amount corresponding to the CPU of their members, and deposit the difference in the Solidarity and Guarantee Fund (FOSYGA). This fund is responsible for

reimbursing the insurers and assigns them any shortfalls due to expenses not covered by the CPU, known as non-POS expenses.

1.10 **SGSSS results.** After 20 years of operation, Colombia's health care system has made major gains in insurance coverage, access, equity, and financial protection for households.

1.11 Coverage has tripled from the level that existed prior to passage of Law 100, in 1993, and Colombia is nearing universal coverage for health insurance. As of December 2012, 91.1% of the total population was covered by the SGSSS. Access to services has steadily increased. Quasi-experimental studies comparing figures for 1997 and 2003 indicated that the likelihood of obtaining an outpatient appointment, when needed, was 40% higher among the insured than among the uninsured;[1] the percentage of poor women who received four prenatal check-ups increased from 41.5% in 1990 to 86.2% in 2011; while between 1993 and 2010, access to medical care during delivery rose by 116% for women in the poorest segments of the population.

1.12 As of 2013, 95% of the urban population reports out-of-pocket spending on health care of less than US$200 per year,[2] while in 2010 private spending represented 27.3% of total health care expenditures—a figure comparable to the average for Organization for Economic Co-operation and Development (OECD) countries (28.2%), and less than the average for Latin America and the Caribbean (42.5%).[3]

1.13 **Challenges facing the SGSSS.** Despite the achievements cited above, and consistent with the first operation in this programmatic series, Colombia's SGSSS faces the following major challenges: (i) the care model has shortcomings in terms of both its capacity to produce positive outcomes and its comprehensiveness; (ii) the system's financial sustainability is being jeopardized by increased spending on medications not covered by the POS, together with the complexity of the financial management system; and (iii) the inspection, surveillance, and control (ISC) system, which is critical for a system that is as deconcentrated and decentralized as Colombia's, has experienced difficulties in implementation.

1.14 **The care model**, in terms of the services provided, has emphasized cure over prevention and health promotion efforts. Access to high-quality primary care has become difficult, with 40% of the urban population having to wait more than six days for an appointment with a general medical practitioner, while for a group of 11 OECD countries, only 15.6% of the population has similar wait times.[4] Due

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1 Giedion U., et al. (2009).

2 IDB (2013). Encuesta de Percepción de los Usuarios de los Servicios de Salud en Colombia [Survey on the Perceptions of Users of Colombia's Health Care Services] RG-K1250.

3 WHO (2013). Out-of-pocket expenditure on health.

4 IDB data comparison (2013) Survey of Perceptions of Users 2013 (RG-K1250), with Schoen C., et al. (2010).

to the problems of accessing primary care, 47% of Colombia's population reports using emergency rooms as the point of entry to the network of services,[5] resulting in worse health outcomes and higher costs than would be the case for primary care.[6] In a group of seven OECD countries, 85%[7] of the population believes that if they become ill, they will receive the best treatment, while in Colombia only 66% have a similar belief. The prevailing service model has created regional inequalities. For example, 16% of the rural population was unable to access health care services when needed, because the medical center was far away, compared with 2.3% for the urban population. Fewer users rate the quality of health care services as "unsatisfactory" in urban areas (22.5%) than in rural areas (34.1%).[8] These disparities are due, in part, to geography and the lack of comprehensive, coordinated health care services in remote areas, leading to greater inequity in health care.

1.15 **Financial sustainability.** Evidence indicates that the main determinant of increases in per-capita spending on health care in recent decades has been the emergence and use of ever more expensive medical technologies.[9] The increased cost of technology in Colombia can be seen primarily in increased requests for new technologies that were not included in the POS. These "non-POS" services are offered using exceptional mechanisms[10] and are paid to the provider once FOSYGA gives the Health Promotion Enterprise the necessary billing approval, as "reimbursement payments." These payments have been increasing at a rapid rate, from Col$0.1 trillion in 2004 to nearly Col$2.4 trillion in 2010, an amount equivalent to almost 20% of the Contribution-based Regime's receipts for the year.[11] According to a Bank study,[12] the largest portion of the public resources used to finance these "non-POS" services are for medications, including high-cost, latest-generation biotechnological medications. Health Promotion Enterprise

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5 IDB data (2013). Survey of User Perceptions of Users 2013 (RG-K1250).

6 Extensive evidence highlights the importance of emphasizing primary care in optimizing health outcomes and minimizing costs: Kringos, et al. (2013); Starfield (2012); Schoen, et al. (2010); Bodenheimer, et al. (2009); WHO (2008); Macinko, et al. (2006); Bindman, et al. (2005); Macinko et al. (2003).

7 IDB data (2013). Survey of Perceptions of Users 2013 (RG-K1250).

8 2010 National Demographic and Health Survey.

9 See Chernew, M. (2011) or Bodenheimer, et al. (2005).

10 When a person is denied a service that is not included in the POS, the person may appeal the denial (through a claim). It is also possible to submit an administrative claim for consideration by a Technical Scientific Committee. If the judge, or the Committee, decides in favor of the citizen, the Health Promotion Enterprise must provide the care and subsequently request reimbursement, to be charged to the State through the Solidarity and Guarantee Fund (FOSYGA). This is what is known as a reimbursement.

11 IDB (2012). Una primera mirada a las experiencias internacionales de los procesos de priorización de medicamentos en salud [An initial look at international experiences with procedures for prioritizing medications].

12 IDB (2012). Ibid.

debt to Service Provider Institutions for non-POS expenditures is calculated to be on the order of Col$4 trillion, thus impacting service delivery.

1.16 This increase in expenditures is coupled with the complexity of the system's financial management structure. One problem is the lack of information from the system's governing body, the Ministry of Health and Social Protection (MINSALUD) on the amount of SGSSS resources. Financing for the system comes from 14 different sources, with the most important ones for the Subsidized Regime funded by the nation's current revenues and the General Share-out System,[13] and financing for the Contribution-based Regime coming from payroll contributions. Among this range of sources, MINSALUD only has information on the General Share-out System and Health Promotion Enterprise surpluses, while it has no information on total collections or other sources of financing. This information gap has left the system with no ability to plan for expenses in the overall system. A further problem is the management of collections on the part of the Health Promotion Enterprises. They collect contributions to the two regimes and make payments to the Service Provider Institutions. However, it has become clear that the Health Promotion Enterprises tend to seek out financial profit,[14] controlling costs at the expense of quality, while holding off payments to the providers.[15] Lastly, membership in the two regimes occurs directly through the Health Promotion Enterprises, which have no incentive to report attrition rates, nor any reason to facilitate mobility between insurers or regimes. They do, however, have incentives to select members based on their risk profiles, so as to be left with only those who will generate the lowest costs, while working to avoid having members join who require extensive medical interventions.

1.17 **Inspection, surveillance, and control system.** Colombia, as part of the 1993 Health Reform (Law 100), created the National Superintendency of Health (SNS) for inspection, surveillance, and control of the public and private stakeholders involved in insuring and providing health services. Current analysis indicates that a series of legal and institutional barriers has hindered the implementation of an

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[13] The General Share-out System is designed to finance the nation's expenditures on health care, education, and water. This account's share of the nation's current revenues is established by the Constitution.

[14] SUPERSALUD, 2012. In 2012, the Health Promotion Enterprises collected nearly Col$25.3 trillion, generating close to Col$1.35 trillion (an amount equivalent to the CPU for the Contribution-based Regime's 2,372,817 members) in financial earnings in the insurers' bank accounts, which could have been reinvested in the system.

[15] Ministry of Health and Social Protection, 2012. It is estimated that, as of 31 December 2012, the SGSSS's debt to the provider network was Col$4.9 trillion, of which 57.2% was in the over-60-day portfolio (SUPERSALUD, 2012). The Health Promotion Enterprises in the Contribution-based Regime accounted for most of the debt (Col$1.7 trillion, with 59% of this in the overdue portfolio), followed by the Health Promotion Enterprises in the Subsidized Regime (Col$1.4 trillion, with 67.7% of the total in the overdue portfolio). In other words, the Health Promotion Enterprises accounted for Col$3.1 trillion (close to 63%) of the total debt. This level of indebtedness places nearly 40% of the public Service Provider Institutions at a high degree of fiscal and financial risk.

effective ISC system. These include: (i) the diversity and number of actors overseen by the SNS; (ii) the centralized nature of the institution; (iii) the proliferation of rules and regulations; (iv) weak inter- and extra-institutional coordination; and (v) lack of sufficient human resources.

1.18 **Reforms envisaged.** Faced with these challenges, the Government of Colombia, through MINSALUD, has proposed an agenda of reforms covering the following main areas: (i) centralizing collections, membership and payments, through the creation of an independent administrative unit; (ii) redefining the benefits plan and expanding its coverage, but specifying exclusions, as well as regulating and controlling medication prices; (iii) transforming the insurance and service delivery model by creating Health Management Units—administrative units charged with overseeing the health of the population in a given geographic area; managing risk; fostering health promotion and disease-prevention activities; and coordinating and monitoring the service delivery network. The new health care model should include the design and implementation of differentiated schemes to take account of special geographic and social conditions; and (iv) strengthening ISC functions.

C. The government's commitment

1.19 The government has been adopting a series of measures to address the agenda of reforms cited above, including both legislative initiatives and administrative measures.

1.20 **Law 1438 of 2011.** This law provided for outright drawings from FOSYGA to the service providers. This has allowed resources from the General Share-out System to go directly to the providers, without having to first go through either the departments or the Health Promotion Enterprises, thus providing timely payments to the Service Provider Institutions and preventing service shut-downs.

1.21 **Tax Reform, Law 1607, of 2012.** This law is aimed at formalizing labor by reducing employers' parafiscal costs. It exempts employers from paying health care-related contributions for employees who earn less than 10 times the minimum wage, in exchange for paying an annual tax on earnings. This is intended to increase the formalization of labor, thereby increasing the Contribution-based Regime's share of the system. Currently, 47% of insured persons are in the Contribution-based Regime, while 53% are in the Subsidized Regime.[16]

1.22 **Statutory Health Care Law.** In June 2013, the national Congress approved the Statutory Health Care Law, to "guarantee the right to, and regulate, health care, and to establish protection mechanisms." This law establishes the State's

[16] National Superintendency of Health, 2012. Entidades Promotoras de Salud Régimen Contributivo y Subsidiado [Health Promotion Enterprises in the Contribution-based and Subsidized Health Care Regimes]. Financial Status Report, December 2012.

obligation to provide patients with all of the health services and technologies their doctors prescribe, except for cosmetic or elective procedures, those not scientifically proven to be safe and effective, procedures not sanctioned by the country's health authorities, experimental procedures, and services that have to be provided outside the country. The law establishes that the expansion of benefits will be gradual and gives the Government of Colombia two years (until June 2015) to define the mechanisms for exclusion and inclusion.

1.23 The law was presented by the government to give users access, through the health care system, to non-POS medications and procedures, with the understanding that it would avoid the bureaucratic procedures needed for patients to obtain approval, on an exceptional basis, from their insurers. The law is also expected to reduce administrative costs for the State, caused by the expense of the corresponding oversight procedures. The Colombian government paid an annual average of US$10 million[17] to process, on average, 100,000 such requests per year between 1997 and 2012.[18] Thus, the government calculates that by covering what has been medically prescribed as necessary by doctors exercising their independent medical judgment—with the exceptions mentioned earlier—the costs for health care technology currently being paid on an extraordinary basis can be rationalized. In addition, there are expected to be gains from greater opportunities for care and from savings in administrative costs. Given that the law is statutory in nature, it requires the approval of the Constitutional Court, which is expected to issue its decision in the first half of 2014.

1.24 **Ordinary Law.** Draft Law 210, of 2013, which "redefines the SGSSS," was presented during the first half of 2013. In October, it was approved by the national Senate, and at present it is in the discussion and approval stage in the House of Representatives. June 2014 will be the last legislative opportunity for it to be approved. The Draft Law seeks to transform the model for delivering services, by strengthening the capacity to produce positive health outcomes at the primary care level—a capacity that is currently concentrated in higher-cost specialized levels of care; and to manage the system's resources, attempting to make collection, membership, and payment tasks more efficient; and establishing mechanisms for determining which technologies, pursuant to the Statutory Law, will be excluded from the benefits plan—whose name will be changed from the Mandatory Health Plan, or POS, to "Mi-Plan" ["My Plan"]—and building the system's ISC capacities.

1.25 **Circulars regulating the prices for medications and timeliness of delivery.** In 2006,[19] controls on the prices of medications in Colombia were eliminated and

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[17] Nieto, E. and Arango A., 2011.

[18] Cardona, J, ¿Cuánto costaría un plan de beneficios de salud integral? [How much would a comprehensive health benefits plan cost?], Document prepared by the IDB, 2013.

[19] Ministry of Health and Social Protection, Circular Number 04 of 2006.

replaced with a system of "probationary" freedom to set prices, in which the only requirement was to report the sales price of the medication in the Medication Price Information System (SISMED). The new system was instituted because the prices paid for medications within the health care system was many times higher than the prices seen in high-income countries.[20] In 2010, the Government of Colombia issued Resolution 5229 establishing maximum values for medications eligible for reimbursement; this succeeded in halting the trend toward increased spending in this area. However, sales prices remained subject to the probationary system until August 2013, at which time Circulars 03 and 04 were issued. These established a methodology for incorporating a direct price control scheme and fixed maximum sales prices for 189 medications used throughout the nation. According to MINSALUD, this decision is saving the SGSSS approximately US$150 million per year.[21]

1.26 **Decree 4023 of 2011.** This decree requires insurers to open accounts to be used exclusively for incoming contributions and allows FOSYGA access to the accounts. MINSALUD already has partial information (relating only to the consolidated balances of the Health Promotion Enterprises) on one of the system's most important sources of financing.

1.27 **Tools for citizen monitoring of insurers and providers. A** number of instruments have been developed to allow for monitoring by SGSSS users. Notable among these is Convention 139, of 2013, agreed between MINSALUD and the Office of the People's Advocate, which requires both parties to make mass disclosures of the rights and obligations of SGSSS users, develop and provide a widely disseminated publication with a ranking of insurers, and conduct annual surveys to evaluate the services offered by insurers and providers.

1.28 **Programmatic policy-based loan (PBP), with support from the IDB.** In this framework of reforms, the government requested that the Bank provide a PBP for the health sector, to assist MINSALUD in carrying out some of the necessary reforms. The disbursement for the first PBP operation (CO-L1127) was made in August 2013, after fulfillment of all the conditions established in the corresponding Policy Matrix. The progress achieved to date is described in paragraphs 1.29 and 1.30 below.

1.29 Draft Law 210 was prepared and presented to the nation's Congress, and includes the following elements, which have also been agreed with the IDB: (i) presentation of a proposal for reorganizing the health care model, which includes the creation of Health Management Zones, overseen by Health Management Unit, responsible for identifying and classifying risks, prevention,

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[20] IDB (2012). Una primera mirada a las experiencias internacionales de los procesos de priorización de medicamentos en salud [An initial look at international experiences with procedures for prioritizing medications].

[21] www.eltiempo.com/opinion/columnistas/alejandrogaviria/ 30 November 2013.

and providing links with the provider network, with a first-level gateway to the system and with capacity to produce positive health outcomes, for residents of the corresponding region. The Health Care Managers, unlike the current Health Promotion Enterprises, will not oversee collections, membership, or payments, but will cover the Health Promotion Enterprises' administration costs and pay them based on their health outcomes; (ii) creation of a Health Management Unit, SALUD MIA, which will centralize the handling of collections, membership and payments; and (iii) allocation and regulation of the administrative instrument for SNS's assumption of the duties of the Health Management Units, providers and territorial health offices to guarantee the delivery of services.

1.30 In terms of administrative edicts aimed at implementing the reforms, MINSALUD: (i) designed the management and health care service delivery model for remote areas; (ii) created and put into operation the Institute for the Evaluation of Health-related Technologies (IETS), and the Regulation, Benefits, Costs and Fees Division of MINSALUD; and (iii) gained approval for the National Pharmaceutical Policy by the National Economic and Social Policy Council (CONPES-Social 155).

D. Strategic alignment

1.31 The present operation is part of the current country strategy with Colombia (2012-2014) (document GN-2648-1), with the objective of improving the quality and sustainability of the SGSSS. Furthermore, it is aligned with the objectives set forth in the IDB's Ninth General Capital Increase (document AB-2764). The reforms that support this operation are aligned with the priority of the lending program to reduce poverty and enhance equity, and will contribute to achieving the regional targets of the Social Policy Strategy promoting equality and productivity, by increasing the number of people benefiting from a basic health care package. It also supports new efforts to expand preventive health protocols and to implement measures aimed at addressing the epidemiological transition of the region's population.

E. Objectives and components

1.32 The objective of this series of two operations is to support the design and implementation of SGSSS reforms, as a means of generating ongoing improvement in health outcomes, enhancing financial protections for the users, and ensuring the long-term sustainability of the system. The reforms to be introduced are expected to strengthen the health care system by establishing a service delivery model that improves health outcomes, emphasizes management of the risk of illnesses through prevention, equitable access to high-quality health care services, efficiency in managing resources, the rational and equitable use of health-related technologies, and improved inspection, surveillance, and control in the health sector.

1.33 This second and final operation in the PBP series maintains the three original components that the IDB agreed on with the government for the first operation.

These components will help ensure implementation of some of the reforms that have been identified as vital to maintaining gains made in the system, while working to overcome current problems in the system. Similarly, the agreed conditions remain in place, with the exception of a change in one of the conditions of Component 3, which is detailed later in this document. The conditions and documentation certifying compliance with the relevant conditions are detailed in the Policy Matrix (Annex II).

1.34 **Component 1. Macroeconomic framework**. The objective of this component is to ensure a macroeconomic environment consistent with the program's objectives and with the guidelines of the sector policy letter.

1.35 **Component 2. Redefinition of the SGSSS.** This component seeks to strengthen the SGSSS by: (i) reorganizing service delivery; and (ii) establishing incentives for risk management in the area of health.[22]

1.36 As cited earlier, for the first PBP operation, the government presented to the Congress Draft Law 210, which proposed a new model for delivery and management of health care services and set forth the health care model for remote areas.

1.37 For this second PBP operation, the following conditions have been agreed on: (i) that the legal viability of the health care model involving a differential approach for remote areas will have been established (Department of Guainía). In these areas, the insurance model has not functioned adequately, due to the low number and density of the population. This operation expects to have the support of a presidential decree, through which the current health care management model will be altered for the Department of Guainía;[23] and (ii) that MINSALUD will have defined a payment model that provides incentives for achieving positive health outcomes, as a means of aligning the system's operation with the health outcomes it produces.

1.38 **Component 3. Greater efficiency and equity in managing health care resources.** The objective of this component is to promote efficiency and equity in the collection and administration of health care resources, while rationalizing the use of health-related technologies.

1.39 For the first PBP operation, the government presented Draft Law 210, which envisages the creation of a Health Management Unit with administrative, financial, and budgetary autonomy, centralizes information on membership and collections, and makes payments directly to providers in the two insurance regimes. There have also been results from the administrative measures taken to

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[22] There is extensive international evidence that a system of performance-based payments, when well designed, contributes to achieving improved health outcomes and increased efficiency in spending (see bibliographic data).

[23] The academic literature confirms the need for managing health care in remote rural areas differently from how it is managed in urban areas. (See bibliographic data II).

build institutional capacity, aimed at prioritizing health care spending (IETS and Benefits, Costs, and Fees Division) and establishing a national pharmaceutical policy.

1.40 For this second PBP operation, the government has agreed to meet the following conditions: (i) that technical specifications for the information system on the collection of contributions for the Contribution-based Regime and membership in the two regimes will have been developed; and (ii) regulations governing medication prices and the use of biotechnological medications will have been established, and transparency in market information will be provided. The first of these conditions includes a change in the trigger mechanism agreed in the first operation, namely, "that technical specifications for the structure of the information system to be used by the Health Management Unit for the unified handling of SGSSS resources have been prepared." Given that the Health Management Unit depends on the approval of the Draft Law, it was decided to prepare the technical specifications for an information system as part of MINSALUD, thus making it possible for it to control the information that the Health Management Unit would oversee. The agreed condition for this second PBP operation provides MINSALUD the tools to allow it to control information on collections and membership, independent of the creation of the Health Management Unit. Although it does not yet centralize these functions, it is making progress in controlling information and, with this, in overseeing membership, mobility of members, and in controlling the resources collected, used, and paid back into the FOSYGA compensation fund. With regard to the second condition—the regulation of medication prices, and particularly the areas of biotechnological medications and transparent market information—the plan is for the SGSSS to improve control over expenditures in that category, which, as mentioned in paragraph 1.15, is the main reason for the increased spending on health care in recent years.[24] The measures adopted to date, outlined in paragraph 1.25, already take account of savings to the system.

1.41 **Component 4. Inspection, surveillance, and control.** This component seeks to strengthen ISC functions in the health care system, which requires strengthening the SNS as the body charged with carrying out these functions. The SNS is expected to have the capacity to exercise these ISC functions in order to ensure the delivery of services, put in place preventive and corrective measures, and impose sanctions when necessary.

1.42 For the first PBP operation, the government demonstrated that Draft Law 210 included measures to strengthen the ISC capacity of the SNS and of its branch

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[24] The literature on prioritizing and controlling health care expenditures shows that spending on health-related technologies is the largest contributor to increases in total health care spending, thus highlighting the need to establish measures to control and rationalize such spending, based on successful experiences. (See bibliographic data III).

offices, and to prepare a proposed executive decree for the reorganization of the entity.

1.43 For the second PBP operation, MINSALUD, the Ministry of Finance and Public Credit (MHCP), and the Office of the President of the Republic are to approve regulations to reorganize the SNS. The present operation supports the government's progress towards issuing a decree modifying the internal structure of the SNS, providing for its deconcentration and decentralization and giving it greater powers to impose sanctions.

F. Main expected outcomes

1.44 As indicated in the framework document for this series, the expected outcomes of the programmatic operations are conceived in terms of short- and medium-term changes; in this particular case, these are expected to be the consequence of implementing reform measures designed to produce ongoing improvement in health outcomes, better financial protection for users, and enhanced long-term financial sustainability for the system.

1.45 The Results Matrix presents the indicators for monitoring the program's effectiveness regarding the establishment of a service delivery model in remote areas that contributes to improving health outcomes, emphasizes effective management of risk of illnesses through prevention, equitable access to high-quality health care services, greater efficiency in managing resources, rational and equitable use of health technologies, and improved ISC in the health sector. Success in achieving these objectives will be measured through indicators on: (i) reducing the mortality rate in a pre-determined remote area; (ii) rationalizing the collection and management of financial resources in the health sector and reducing medication prices; (iii) giving priority to the most cost-effective expenditures in regard to health-related technologies; (iv) improved ISC in the health sector; and (v) increasing insurance coverage.

II. FINANCING STRUCTURE AND RISKS

A. Financing instruments

2.1 This is the second and final operation in a series structured as programmatic policy-based loans (PBP), each having a single tranche, pursuant to document CS-3633, "Policy-based Loans: Guidelines for Preparation and Implementation." The amount of the present operation is US$400 million, financed with resources from the Bank's Ordinary Capital, under the Flexible Financing Facility. A programmatic series was based on its ability to strengthen policy dialogue with the government regarding regulatory reforms and managing the SSSGS, and on the ability to provide greater flexibility in adapting to changes in strategy for implementing the reforms over the medium term.

B. Environmental and social risks

2.2 This PBP operation does not finance physical investments, nor does it envisage activities with adverse effects on natural resources and, therefore, does not require an ex ante impact classification (B.13) under the Environment and Safeguards Compliance Policy (OP-703). The program is expected to have a positive social impact, improving access to high-quality health care services in the country, particularly in remote areas, including areas with indigenous populations.

C. Economic analysis

2.3 The ex ante economic evaluation quantified the possible effects of two key changes associated with reforms to the health sector: (i) improving the processes for becoming a member of the insurance system, collecting contribution payments, and making payments to the providers, all of which are currently functions delegated to the insurers; and (ii) creating Mi-Plan, which is to be a greatly expanded and more comprehensive benefits plan than what is now in place—one that offers the same premium and scope for all citizens regardless of their socioeconomic level. The evaluation also quantified the expected impacts of tax reform on the SGSSS's ability to mobilize resources. Lastly, it performed a qualitative analysis of the potential benefits, costs, and risks involved in establishing the Health Management Unit, the system of performance-based payments, Health Management Zones, and vertical integration with the primary health care level.

2.4 The analysis concluded that the reforms to the process of membership, collections, and payment will generate a net reduction in operating costs of nearly Col$90 billion per year, and will increase financial returns by close to Col$950 billion, with resulting net gains of Col$1.04 trillion per year. The introduction of Mi-Plan will increase the system's cost by Col$1.38 trillion to equalize the CPUs of the two regimes, and by Col$2 trillion to increase coverage of the benefits package, which would be more than offset by the resources mobilized for the SGSSS as a result of the tax reform. At the same time, the inclusion of services currently not covered in the POS is expected to lead to a reduction in the use of administrative and judicial mechanisms, which in turn would reduce the associated administrative costs, which are estimated to be Col$50 billion per year. In summary, the quantification of economic benefits indicates that the reforms supported by this program will ensure the economic sustainability of the SGSSS.

2.5 Similarly, preliminary estimates of the impact of Mi-Plan on equity show that there will be a major redistributive effect. The Gini coefficient will change by around three percentage points for the Subsidized Regime, and by approximately one percentage point in the Contribution-based Regime.

2.6 **Risks.** The ideal scenario for the government to be able to advance all of the proposed reforms would be the approval and enactment of the Ordinary Law. The legislative period for passing this bill ends in June 2014. However, given the

urgency of the adjustments, the risk of failure to gain approval, and the political economy of the sector and the electoral environment, the government has developed mitigation measures, putting forward reform proposals that could be implemented through administrative decrees that would have legal legitimacy within the existing regulatory system. In the discussions held with system stakeholders since the draft law was first presented, agreements have been emerging that many of the adjustments the system needs can be made without a law and the Ministry cannot put off moving forward with these adjustments. Examples of this were cited in Section I.C of the present document.

2.7 Given the large number of interest groups surrounding the health sector, such as insurers, subnational governments, clinics and hospitals, medical associations, the pharmaceutical industry, and patient groups, any reform to the health care system is bound to affect one or more of these interests. This explains the sensitivity of the issues and the resistance to change that authorities in the sector face. Thus, the government is promoting reforms through legislative initiatives, while simultaneously advancing regulatory and administrative measures within its purview, in an effort to work through the various challenges the system is facing.

III. Implementation and Action Plan

A. Summary of implementation measures

3.1 The borrower is the Republic of Colombia. Execution of the program and use of the Bank's financing resources will be carried out by the borrower, through the MHCP, which will be designated as the executing agency. The executing agency, in turn, will conduct the program in coordination with the National Planning Department (DNP), which will be responsible for coordinating with MINSALUD on monitoring fulfillment of the policy measures necessary for the reform of the SGSSS proposed under the program.

B. Summary of measures for evaluation and monitoring of outcomes

3.2 Program monitoring involves verifying compliance with the policy measures agreed to as loan disbursement conditions. There will, however, be monitoring of the outcomes of the reforms, using the indicators detailed in the Results Matrix and implementing the following instruments: (i) a before-and-after evaluation of indicators associated with the performance of the health care system, using an existing baseline for 2013, as well as a national survey of users of the health care system, to be financed with technical cooperation resources from the Bank (RG-T1873 – ATN/SF-12486-RG), the results of which can be found in the attached document (Implementing and Designing High-Quality Primary Health Care: Outcomes in Colombia I and II); and (ii) a quasi-experimental evaluation of the special model for remote areas, to be executed with Bank cofinancing from the technical cooperation operation, Piloting an Experimental Model of Health Service Delivery (CO-T1318 – ATN/OC-13864-CO).

C. Policy letter

3.3 The Policy Letter agreed on with the Government of Colombia and presented by the DNP, with support from MINSALUD, describes the macro and sectoral policy measures that the country is implementing and plans to carry out. These measures are consistent with the program's objectives.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	**Aligned**		
Lending Program	**i) Lending for poverty reduction and equity enhancement.**		
Regional Development Goals	**i) Infant mortality ratio.**		
Bank Output Contribution (as defined in Results Framework of IDB-9)	**i) Individuals (all) receiving a basic package of health services.**		
2. Country Strategy Development Objectives	**Aligned**		
Country Strategy Results Matrix	**GN-2648-1**	**To improve the health sector´s quality and sustainability.**	
Country Program Results Matrix	**GN-2756**	**The operation is included in the 2014 Country Program Document.**	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	**Highly Evaluable**	**Weight**	**Maximum Score**
	9.7		**10**
3. Evidence-based Assessment & Solution	**9.6**	**33.33%**	**10**
3.1 Program Diagnosis	**3.0**		
3.2 Proposed Interventions or Solutions	**3.6**		
3.3 Results Matrix Quality	**3.0**		
4. Ex ante Economic Analysis	**9.5**	**33.33%**	**10**
4.1 The program has an ERR/NPV, a Cost-Effectiveness Analysis or a General Economic Analysis	**2.5**		
4.2 Identified and Quantified Benefits	**2.0**		
4.3 Identified and Quantified Costs	**2.0**		
4.4 Reasonable Assumptions	**2.0**		
4.5 Sensitivity Analysis	**1.0**		
5. Monitoring and Evaluation	**10.0**	**33.33%**	**10**
5.1 Monitoring Mechanisms	**2.5**		
5.2 Evaluation Plan	**7.5**		
III. Risks & Mitigation Monitoring Matrix			
Overall risks rate = magnitude of risks*likelihood	**Medium**		
Identified risks have been rated for magnitude and likelihood	**Yes**		
Mitigation measures have been identified for major risks	**Yes**		
Mitigation measures have indicators for tracking their implementation	**Yes**		
Environmental & social risk classification	**B.13**		
IV. IDB´s Role - Additionality			
The project relies on the use of country systems			
Fiduciary (VPC/PDP Criteria)			
Non-Fiduciary			
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality			
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	**Yes**	The Bank has been supporting and working with the Government in order to guarantee the sustainability of the health system, through three different technical cooperations, one regional and two country specific (ATN/SF-11853 RG, ATN/OC-13369-CO y ATN/FI 12861 CO). These TCs support the design of "Mi Plan", as well as the structuring of a new institution for the evaluation of sanitation technologies and the definition of a pharmaceutical policy.	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan	**Yes**	The quasi-experimental impact evaluation of the new attention model for regions with isolated populations will answer the following questions: what is the effect of the health community model on the general health conditions of Guainía's population? What is the impact of the family attention model in the resolution and mortality rates in the Guainía department? Moreover, the evaluation will generate information to improve the current model and reduce inequality in the provision of health services.	

This project is the second operation of a programmatic series to support health system reform in Colombia. Its main objective is to assist in the design and implementation of the Colombian health sector reform, as to improve health conditions among users and guarantee the system´s financial sustainability in the long run.

The loan proposal presents a solid logic and a clear line of reasoning. Based on empirical evidence, it describes the achievements of the existing system since the approval of 1993´s Ley 100, as well as the persisting challenges that make the government proposed sector reform necessary. In particular, it highlights improved insurance coverage and access to services, on the one hand; but the lack of response capacity, financial unsustainability and management difficulties, on the other. As causal factors of such problems, the proposal mentions and documents, primarily, the curative approach of the attention model, the increasing non-POS services provided, the complexity of the financial structure and the very low profile of the oversight and control agency.

In order to solve the existing challenges in the Colombian health system, the document proposes to support the sector´s reform agenda, which has been promoted by the government and reflects its commitment to the cause. The reform consists of: i) creating an independent administrative unit for managing collection, enrollment and payments; ii) redefining the benefit plan; iii) establishing health managers as a unit in charge of insurance; and iv) strengthening the oversight and control agency. The document justifies these actions based on detailed analyses of the current situation and includes references about the effectiveness of some of the proposed models. However, it lacks an analysis of the potential to replicate the results cited in the Colombian context.

Policy and results matrices are appropriate and consistent. The results matrix presents SMART indicators for results and products, but does not include impact indicators. The economic analysis annex presents a general economic study of the project where some of the benefits and costs of reform are quantified under reasonable assumptions. The monitoring and evaluation plan is appropriate. A retrospective evaluation is proposed based on a user satisfaction survey, to measure changes in access and quality resulting from the overall set of actions included in the reform. In addition, an impact evaluation using quasi-experimental methods will be carried out, to assess the new attention model for sparsely populated areas in the Guainía department.

The risk matrix is adequate. It identifies and describes project risks according to their impact and likelihood of occurrence. It also proposes mitigation measures and indicators to track their implementation.

POLICY MATRIX

Objectives	Conditions fulfilled in 2013	Conditions for the 2014 operation*	Means of verification for 2014
1. Macroeconomic framework			
Stable and sustainable macroeconomic and fiscal framework to support the viability of program objectives.	Maintain a stable macroeconomic framework consistent with program objectives.	Maintain a stable macroeconomic framework consistent with program objectives.	Independent Assessment of Macroeconomic Conditions.
2. Redefinition of the General Social Security Health Care System (SGSSS)			
Strengthening of the SGSSS by reorganizing service delivery and introducing incentives for risk management in health.	(2.1) The government prepared and presented to the Congress a bill redefining the SGSSS that lays out the structure of health services delivery, the role of the various personnel involved, and the incentives for achieving health outcomes, with an emphasis on prevention.	(2.1) That the Ministry of Health has defined a model of incentives for achieving positive health outcomes.	▪ Technical document prepared by the Ministry of Health that includes guidelines for a results-based payment model and the design for a pilot project. ▪ Resolution encouraging health results in chronic kidney disease.
	(2.2) The Ministry of Health identified the general guidelines for a service delivery system in regions with dispersed populations, through a technical document that establishes a model for health services, with a differential approach.	(2.2) That the legal viability of the health care operational model, using a differential approach to serving areas with dispersed populations, is established (Department of Guainía).	Decree sanctioned by the President of the Republic.

Objectives	Conditions fulfilled in 2013	Conditions for the 2014 operation*	Means of verification for 2014
3. Greater efficiency and equity in managing health care resources			
Promote efficiency and equity in the collection and administration of health care resources, along with rationalizing the use of health-related technologies.	(3.1) The government prepared and presented to the Congress a bill redefining the SGSSS that calls for the creation of a management unit with administrative, financial, and budgetary autonomy, in order to provide unified management of the resources for financing the system.	(3.1) That technical specifications for the information system for the collection of contributions for the Contribution-based Regime and from membership in both regimes has been developed.	▪ Decree 4023 regulating the compensation process and the operation of the internal compensation subaccount of the FOSYGA Contribution-based Regime sets rules for the collection of contributions to the Contribution-based Regime of the General Social Security System and issues other provisions. ▪ Decree establishing and verifying the rules for membership in the General Social Security Health Care System in the Contribution-based and Subsidized Regimes and through partial subsidies.
	(3.2) The government adopted measures to ensure rational, equitable use of health-related technologies, through: (i) institutional strengthening of the entities involved; and (ii) establishment of a national pharmaceutical policy.	(3.2) That the regulations governing the price of medicines, the use of biotechnological medicines, and transparency in market information have been formulated.	▪ Circular 07 of 2013, which incorporates certain medications in the direct control regime, based on the methodology detailed in Circular 03 of 2013, of the National Commission on the Price of Medications and Medical Devices, setting the corresponding maximum sales prices for the entire nation. ▪ Circular 05 of 2013, of the National Commission on the Price of Medications and Medical Devices, modifying Circular 04 of 2013 ▪ Circular 04 of 2013, of the National Commission on the Price of Medications and Medical Devices, which incorporates certain medications in the direct control regime, based on the methodology detailed in Circular 03 of 2013, of

Objectives	Conditions fulfilled in 2013	Conditions for the 2014 operation*	Means of verification for 2014
			the National Commission on the Price of Medications and Medical Devices, setting the corresponding maximum sales prices for the entire nation. ▪ Circular 03 of 2013, of the National Commission on the Price of Medications and Medical Devices, establishing the methodology for implementing the direct control regime for medication prices sold throughout the nation. ▪ Circular 01 of 2014 of the National Commission on the Price of Medications and Medical Devices, incorporating medicines to the direct control regime, based on the methodology set forth in Circular 03 of 2013, setting the maximum sales price, and amending Circular 07 of 2013. ▪ Draft decree on biotechnologies. ▪ Technical document for standardizing the regulatory process for medicine prices.

Objectives	Conditions fulfilled in 2013	Conditions for the 2014 operation*	Means of verification for 2014
4. Inspection, surveillance, and control (ISC)			
Strengthen the health care system's inspection, surveillance, and control functions.	(4.1) The government prepared and presented to the Congress a bill redefining the SGSSS that calls for strengthening the inspection, surveillance and control capacities of the National Superintendency of Health (SNS) and its branch offices, along with preparation and presentation of a proposed executive decree for its reorganization.	(4.1) That the regulations for reorganization of the SNS, with emphasis on protecting users and overseeing the delivery of services have been approved.	▪ Decree 2462 of 2013 modifying the structure of the SNS. ▪ Decree 2463 of 2013 amending the staffing of the SNS.
Expected medium- and long-term outcomes	**Indicators of expected outcomes**		
	Percentage of the population with a general medical practitioner whom he/she consults regularly to obtain medical care. Rate of hospitalization for conditions susceptible to primary care interventions. Percentage of the population that perceives the medical care system to be functioning well, and that believes only minor changes are needed to make it function better. Ratio of men to women who, due to cost, did not visit or consult a physician when needed. Ratio of institutional deliveries in rural vs. urban areas. Rate of infant mortality for children under 1 in the department of Guainía. Cost of collecting and transferring health care system resources. Percentage of charge-backs with respect to the total value of resources. Population covered by health insurance (percentage). Population covered by health insurance (number).		

* See link, Comparison Matrix. Agreed Conditions for the Second Operation vs. Agreed Conditions in the Loan Proposal for the First PBP Operation.