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COLOMBIA

PROGRAM TO ENHANCE SUSTAINABILITY AND INCLUSIVENESS IN THE COLOMBIAN HEALTH CARE SYSTEM

(CO-L1248, CO-J0011, AND CO-G1019)

LOAN AND INVESTMENT GRANT PROPOSAL

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ABBREVIATIONS

ADRES	Administradora de Recursos de la Seguridad Social en Salud [Social Security Health Care Resource Administration]
BMZ	Federal Ministry for Economic Cooperation and Development – Government of Germany
CGR	Contraloría General de la República [Office of the Comptroller General of the Republic]
DALY	Disability adjusted life years
DANE	Departamento Administrativo Nacional de Estadística [National Administrative Department of Statistics]
DFS	Dirección de Financiamiento Sectorial del MSPS [MSPS Sector Financing Office]
DGRFS	Dirección de Gestión de los Recursos Financieros de la Salud del MSPS [MSPS Office for Health Care Finance Management]
DLI	Disbursement-linked indicators
EPS	Entidades Promotoras de Salud [Health Promotion Entities]
GDP	Gross domestic product
GRF	IDB Grant Facility
IPS	Instituciones Prestadoras de Salud [Health Services Institutions]
MAITE	Modelo de Acción Integral Territorial [Comprehensive Territorial Action Model]
MHCP	Ministry of Finance and Public Credit
MIPRES	Mi Prescripción de Tecnologías en Salud [My Electronic Health Care Prescription]
MRA	Maximum reimbursable amount
MSPS	Ministry of Health and Social Protection
OECD	Organisation for Economic Co-operation and Development
pp	Percentage points
PSG	Project-specific grant
RBL	Results-based loans
RIPS	Registros Individuales de Prestación de Servicios de Salud [Individual Health Care Service Records]
SGSSS	Sistema General de Seguridad Social en Salud [General Social Security Health Care System]
SISPRO	Sistema Integral de Información de la Protección Social [Comprehensive Information System for Social Protection]
SNS	Superintendencia Nacional de Salud [National Health Superintendency]
UNHCR	United Nations High Commissioner for Refugees
UPC	Unidad de Pago per Cápita [Per Capita Payment Unit]
WHO	World Health Organization

PROJECT SUMMARY
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<table>
<tr><th colspan="6">Financial Terms and Conditions</th></tr>
<tr><td colspan="2">Borrower/Beneficiary:</td><td></td><td>Flexible Financing Facility [a]</td><td>Grant Facility</td><td>Project-specific grant (CO-G1019)</td></tr>
<tr><td colspan="2">Republic de Colombia</td><td>Amortization period:</td><td>14.70 years</td><td>N/A</td><td>N/A</td></tr>
<tr><td colspan="2">Executing agency:</td><td>Disbursement period:</td><td>3 years</td><td></td><td></td></tr>
<tr><td colspan="2">Ministry of Health and Social Protection (MSPS)</td><td>Grace period:</td><td>14.70 years [b]</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Source</td><td>Amount (US$)</td><td>Interest rate:</td><td>LIBOR-based</td><td>N/A</td><td>N/A</td></tr>
<tr><td>IDB (Ordinary Capital):</td><td>150,000,000</td><td>Credit fee:</td><td>[c]</td><td>N/A</td><td>N/A</td></tr>
<tr><td>IDB (Grant Facility)[d]</td><td>9,625,000</td><td>Inspection and supervision fee:</td><td>[c]</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Project-specific grant (Government of Germany, Federal Ministry for Economic Cooperation and Development (BMZ)) (CO-G1019)[e]</td><td>2,210,900</td><td>Weighted average life (WAL):</td><td>14.70 years</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Total:</td><td>161,835,900</td><td rowspan="3">Approval currency:</td><td colspan="3" rowspan="3">U.S. dollar</td></tr>
<tr><td>Administration fee:[e]</td><td>110,545</td></tr>
<tr><td>Total available for project:[d]</td><td>161,725,355</td></tr>
<tr><th colspan="6">Project at a Glance</th></tr>
<tr><td colspan="6">Project objective/description: Improve the sustainability of the General Social Security Health Care System (SGSSS) to consolidate gains in coverage, equity, and financial protection, together with health improvements for the general population. The specific objectives are to: (i) improve management of total expenditures on health-related services and technology not funded through Per Capita Payment Units (UPC); (ii) enhance SGSSS efficiency and coverage; and (iii) increase health care coverage for the migrant population (paragraph 1.27).</td></tr>
<tr><td colspan="6">Special contractual conditions precedent to the first disbursement of the financing: The executing agency will submit evidence that it has approved the program operating manual, and the manual has entered into force, under terms previously agreed upon with the Bank (paragraph 3.8).</td></tr>
<tr><td colspan="6">Exceptions to Bank policies: None.</td></tr>
<tr><th colspan="6">Strategic Alignment</th></tr>
<tr><td>Challenges:[f]</td><td>SI ☒</td><td colspan="2">PI ☐</td><td colspan="2">EI ☐</td></tr>
<tr><td>Crosscutting themes:[g]</td><td>GD ☒</td><td colspan="2">CC ☐</td><td colspan="2">IC ☒</td></tr>
</table>

[a] Under the terms of the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule, as well as currency, interest rate, and commodity conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

[b] Under the flexible repayment options of the Flexible Financing Facility, changes to the grace period are permitted provided that they do not entail any extension of the original weighted average life (WAL) of the loan or the last payment date as documented in the loan contract.

[c] 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 policies.

[d] Nonreimbursable financing. The GRF is the Bank's Grant Facility. Pursuant to document GN-2947-6, Bank financing for this operation is structured as a blend of a maximum of 20% nonreimbursable funds (Grant Facility and BMZ) and 80% reimbursable funds (Ordinary Capital). The Grant Facility funds will be disbursed simultaneously and proportionately with the proceeds of the Ordinary Capital loan.

[e] A PSG is a project-specific grant from the Bank. In this program, a grant will be provided by the Federal Ministry for Economic Cooperation and Development of the Government of Germany (BMZ), subject to approval. The proceeds will become available once the German government and the Bank have signed an administration agreement and the Bank has received the funds from the BMZ. The Bank will charge an administration fee in accordance with current Bank policy on fees for administering donor contributions to trust funds and specific project-related contributions. The Bank's Board of Executive Directors is asked to ensure that the proceeds of the administration fee are distributed among the departments supporting the operation, in order to cover the preparation and implementation costs of the BMZ contribution (see paragraph 2.5). The total donor contribution is €2 million (equivalent to US$2,210,900, at an exchange rate of 0.904609 euro per U.S. dollar, as of 24 January 2020).

[f] SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

[g] GD (Gender Equality and Diversity); CC (Climate Change and Environmental Sustainability); and IC (Institutional Capacity and Rule of Law).

I. DESCRIPTION AND RESULTS MONITORING

A. Background, problem addressed, and rationale

1. Progress in health system reform

1.1 With the adoption of Law 100/1993, Colombia began building a national system to provide universal health care coverage, the General Social Security Health Care System (SGSSS). The reform required compulsory enrollment for all residents, established a single fund for contributions, drew distinctions between health care service providers and buyers and, in an effort to stimulate competition, allowed health care plan members the freedom to choose insurance companies. Health care services and public health efforts were delegated at the local level while management, finance, and regulatory tasks remained centralized and became more robust under newly created institutions.

1.2 Health Promotion Entities (EPS) provide coverage under two systems: subsidized plans and contribution-based plans, with each group having approximately 22.5 million members (MHCP, 2018). Individuals under contribution-based plans make salary-based contributions that partially subsidize the subsidized plan. Other funding sources include the National General Budget, intergovernmental transfers and liquor and cigarette tax revenues. In exchange for Per Capita Payment Units (UPC), enrollees have the right to an EPS-managed Health Benefits Plan (PBS) and to non-UPC covered services that the treating physician orders through the My Electronic Health Care Prescription (MIPRES) platform. The Social Security Health Care Resource Administration (ADRES), under the Ministry of Health and Social Protection (MSPS), administers the resource pool, transfers to the EPSs members' UPCs and pays EPSs under the contribution-based plan system for non-UPC funded services and technology (see additional details on the SGSSS in optional link 5).

1.3 **Progress in health care.** The SGSSS has made significant structural progress in terms of coverage, equity, financial protection, poverty reduction and health care outcomes, which must be safeguarded in the global context brought on by COVID-19. The health care plans have 95.7% of the population enrolled (MHCP, 2018) and both types of plans offer the same Health Benefits Plan since 2011. Between 2012 and 2017 more than 500 medications and procedures were added to the Health Benefits Plan. Out-of-pocket expenses (18.3%) are also much lower than the Latin American average (31.3%) and close to those of countries in the Organisation for Economic Co-operation and Development (OECD) (13.8%) (World Bank, 2015). Lastly, of the 12.6 percentage points (pp) for multidimensional poverty reduction between 2010 and 2016, 4 pp reflect improvements to public access to health care services (DANE, 2017).

1.4 Indicators on health care service access and medical outcomes have improved. According to the Health and Demography Survey (ENDS), the infant mortality rate fell from 28 per 1,000 live births in 1995 to 14 in 2015, which is below the regional average (14.9). According to the National Administrative Department of Statistics (DANE), between 2011 and 2018, the maternal mortality rate was cut by almost half, from 68.8 to 36.1 per 100,000 live births. Colombia has an exemplary immunization program and from 2011 to 2018 immunization rates rose for the diphtheria, pertussis, and tetanus (DPT) (from 86% to 93%), tuberculosis (83% to 89%), and

pneumococcal (46% to 94%) vaccines. Wait times for medical consults (3.4 days-general; 10.1-gynocological; 12-internal medicine; 8.8-pediatrics) are better than those of several OECD countries (SISPRO, 2018). At present, the health care system is focused on grappling with the situation caused by COVID-19, which the WHO declared a pandemic on 11 March 2020. As of 11 November, Colombia has had a total of 1,165,326 cases and 33,312 deaths (MSPS 2020). The government has taken measures to lessen the impact of the pandemic, including closing airports and borders, implementing targeted, obligatory quarantines and more than doubling the number of intensive care beds (from 5,343 in early April to 11,219 in early November), thereby managing to keep the system from being overburdened with acutely ill patients. The first spike in the pandemic occurred around the month of August, with 12,000 daily cases and more than 93% of intensive care beds in use. After the surge, the re-opening of economic and social activities expanded again under biosafety measures, along with improved diagnostics, contract tracing and selective isolation. Though the rate dropped to 6,000 daily cases in early October, cases are once again trending upward and in mid-November fluctuate between 8,000 and 10,000 new cases a day.

2. The sustainability challenge

1.5 **Health care expenditure pressures.** The SGSSS faces challenges that threaten its economic sustainability and the gains made in coverage and financial protection. The country is feeling the increasingly intense effects of sociodemographic and epidemiological transitions. The number of persons over 60, who require higher levels of medical care and more complex services, is set to triple, rising from 10.8% of the population in 2015 to 27.5% in 2050 (United Nations, 2017). The middle class went from representing 16.3% of the population in 2002 to 30.6% in 2016, prompting increased demand for health services as higher incomes lead to higher health costs due to rising expectations on quality and scope of care (OECD, 2015). Chronic noncommunicable diseases (CNCD), which usually involve high-cost, long-term treatment, represent 83% of the country's disease burden (Peñalosa, et al., 2014). Between 2009 and 2016, medical care and deaths related to chronic noncommunicable diseases rose 5 pp (MSPS, 2017a) and 7 pp (WHO, 2015), respectively.

1.6 **Country-specific factors.** Certain factors specific to Colombia's SGSSS threaten its financial stability: (i) limited funding against a backdrop of growing demand for new and costly non-UPC funded technology; (ii) a fragmented service model with deficiencies in primary care services and health promotion and disease prevention programming; and (iii) recent waves of uninsured Venezuelan migrants who mostly receive costly emergency medical care. Recently, the COVID-19 emergency has impacted not only health[1] indicators but economic[2] and other social[3] indicators as well. During the first months of the pandemic, the government moved forward with measures to lessen the impact, including the closing of airports and borders, the

[1] Colombia has had a total of 1,041,935 COVID-19 cases and 30,753 deaths (MSPS, 2020).

[2] Gross domestic product for the first quarter of 2020 fell 7.4% and for the second quarter of 2020 had dropped 15.7% compared with the first and second quarters of 2019, respectively (DANE, 2020).

[3] The national unemployment rate for the June-August rolling quarter of 2020 was 18.9% (8.6 percentage points compared to the same period in 2020) (DANE 2020).

implementation of targeted, obligatory quarantines, and increases in the number of ICU beds. Re-opening was possible during a second phase due to biosafety measures, improved diagnostics, contract tracing and selective isolation. Strengthening the health care system's ability to address the challenges described above will enhance its resiliency and ability to respond to emergencies such as those caused by COVID-19. In addition, expanding SGSSS coverage to the migrant population will make it possible to better protect those populations from the risks posed by COVID-19.

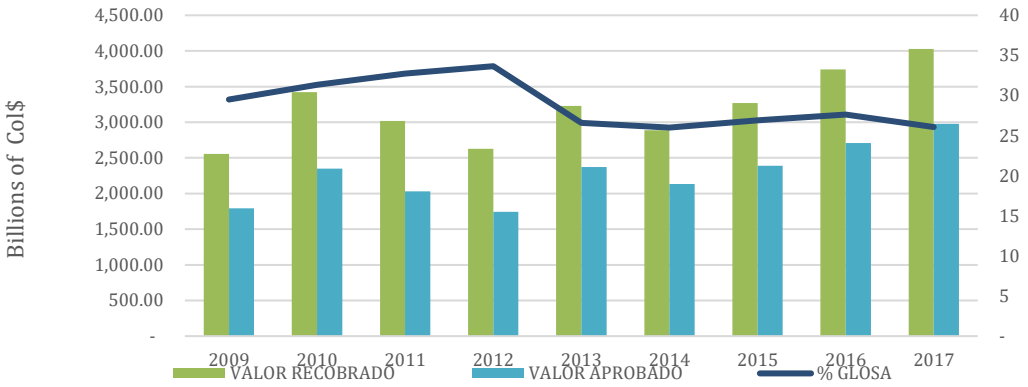
1.7 **Financial imbalances requiring corrective measures**. In 2004, health care expenditures represented 5.4% of gross domestic product (GDP), whereas in 2015 that figure stood at 6.8% (MSPS, 2016). The public sector financed 77% of total health care costs in 2015, a proportion of public spending that is higher than the average for OECD and Latin American countries, which were at 62.2% and 51.2%, respectively (World Bank, 2017). Between 2012 and 2016 public spending on health care grew 24.7%, far outpacing growth in total revenues for SGSSS, which only rose by 8% (MSPS, 2017b). Payroll-based contributions represent the main source of funding and, due to regulatory changes, went from 51% of the total in 2012 to 41% in 2016 (MSPS, 2017b). For this reason, the government has sought to cover funding needs with additional resources from general tax revenues, earmarked funds from alcohol and tobacco revenues and surpluses from the National Pension Fund for Territorial Entities. The growing dependence on National Public Budget funds as a percentage of total resources, which rose from 7.8% to 24.3% (MSPS, 2017b), increases the system's financial vulnerability.

1.8 **Non-UPC funded services.** A weak system for prioritizing health care services (Giedion, et al. 2018) and costly technology-based care not covered by UPC funds are some of the main drivers pushing up costs. Over the last nine years, these types of expenditures under the contribution-based plan system have amounted to between Col$2 trillion and Col$3 trillion per annum (~15% of total spending under the contribution-based plan) (MSPS, 2017b), despite a variety of cost-cutting measures like price regulations for medicines and the inclusion of different technologies under the Health Benefit Plans (Prada, et al., 2018). According to a Fedesarrollo study (2018), technological advances account for an estimated 45% to 67% of the growth in health care costs, which is closely tied to the use of non-UPC funded technology.

1.9 The payment mechanism for non-UPC financed technology, in addition to putting pressure on expenditures, creates financial imbalances in the EPSs and Health Services Institutions (IPS). In the case of a contribution-based plan, the EPSs pay for services then submit requests for reimbursement of paid claims to ADRES. Under the subsidized plan, territorial entities review and pay reimbursement requests for these types of services. Given inherent discrepancies between benefits packages and the complex administrative process for submitting requests for reimbursement, every year a certain amount are not approved, resulting in cash flow deficits (around 25% under the contribution-based plan system, see Figure 1). As a result, the public and private IPSs have accounts receivable portfolios with the EPSs amounting to almost 1.5% of GDP, and the EPSs have unpaid claims with ADRES and territorial entities equal to 0.6% of GDP (SuperSalud, 2017). These imbalances have led EPSs to have levels of insolvency equivalent to 0.73% of GDP

(SuperSalud, 2018), making them noncompliant with the margins stipulated in their chartering documents as insurance agencies.

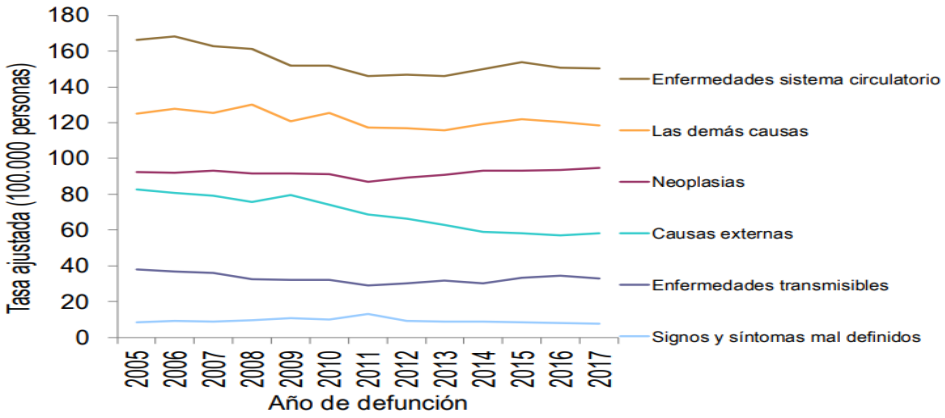
Figure 1. Reimbursements for non-UPC funded health care services paid to EPSs under the contribution-based plan



Source: ADRES, 2018.

1.10 **Imbalances in service delivery.** In Colombia, perceptions of quality primary health care services are low (29.6%) compared with averages for Latin America and the Caribbean (40.5%) and the OECD (68%) (Guanais, et al., 2018). This owes, in part, to the health care services model being more reactive than preventive. For example, while circulatory diseases are the leading cause of death (see Figure 2, Adjusted Mortality Rate per 100,000), coverage for exams to test cholesterol levels in adults over 30 is very low,[4] which is particularly concerning since records indicate mortality rates in this category are higher for men than women[5] (MSPS, 2017) yet men do not receive a correspondingly higher number of diagnostic tests[6] (Guanais, et al. 2018).

Figure 2. Leading causes of death



Source: Health Situation Analysis in Colombia. MSPS 2017.

[4] According to the MSPS (2019a) the 13% coverage is significantly lower than the level required by the MSPS Comprehensive Approach to Promoting and Maintaining Good Health.

[5] In 2017 there were 178.01 deaths per 100,000 men, compared to 127.27 deaths per 100,000 women.

[6] In the past five years, 55.6% of men and 53.1% of women have had their cholesterol levels tested.

1.11 **Health promotion and disease prevention.** The country must close gaps in effective access to priority health services, especially preventive care. According to a World Health Organization (WHO) study, only 57% of the adult population believed to have high blood pressure is aware of the condition, a concerning statistic given that cardiovascular disease causes one in four deaths in Colombia. Another study, financed by the IDB (Buitrago, Ruiz & Rincon, 2018) found that among the diabetic population (324,000 patients) only 15% received the tests that clinical practice manuals recommend for effective diabetic care. In 2017, according to the MSPS, 67% of individuals with HIV were aware of their diagnosis, 54% were receiving treatment for it and, of those, 47% showed suppressed viral loads (MSPS, 2017c).

1.12 **Spending efficiency.** An IDB study that used Data Envelopment Analysis to assess countries' health care spending efficiency ranked Colombia 48th out of the 69 countries studied (IDB, 2018). The study analyzed variables such as health care outcomes, access to services, and equity in service access (Chapter 8 of Better Spending for Better Lives).

1.13 **Immigration.** Recent Venezuelan immigration has had a significant impact on the health sector due to increased medical care provided to the migrant population, the high costs of care, and the deteriorating public health environment in host communities. As of 31 March 2020, Colombia had taken in more than 1.8 million Venezuelans, 38% of whom have a Special Residency Permit and may enroll in the SGSSS. As of May 2020, only 12% (217,751) of the total number of migrants had enrolled in the SGSSS under the contribution-based or subsidized plans (53% and 47%, respectively) because of legal barriers in registration systems, lack of understanding of the processes and requirements for enrollment, or for cultural reasons. Immigrants who have legal status but are not yet enrolled in a health plan and those without legal status both access the health care system through emergency services, the average cost of which is higher than for persons enrolled in the system. Records indicate that 3,931,799 health care services have been provided to 474,539 Venezuelans (21% of whom are pregnant women requiring obstetric care), with requests for government funding topping Col$250 billion. The health system's immigration-related funding gap results, primarily, from the number of uninsured among the migrant population. For more information see optional link 4.

3. Government strategy and program

1.14 **End-point agreements.** The Colombian government's strategy for ensuring sustainable funding for the SGSSS begins with a process for writing off debts among different health sector entities caused by use of non-UPC funded health care technology and the implementation of new measures to avoid new such debt. The first part involves an audit to settle and resolve account discrepancies and make the corresponding payments with treasury bonds, in the case of contribution-based plan, and with possible cofinancing between territorial entities and the national government, in the case of the subsidized plan. Parties will sign contracts in which they acknowledge audit findings and agree to refrain from resolving reimbursement issues through lawsuits and administrative procedures. The National Health Superintendency will verify that insurers and health care providers reflect account settlement processes in their balance sheets and financial statements.

1.15 Some of the most significant measures for averting future debt include the development and setting of maximum budgets that replace the reimbursement

system for managing services and technologies not UPC funded (paragraph 1.9). The approach involves estimating the expected use of services and technologies for each EPS and assigning them Maximum Reimbursable Amounts (MRA) based on the 25th percentile historically paid. The budget ceiling is calculated based on these two parameters. Additionally, the EPS is responsible for comprehensive management of those services. This methodology cuts costs (even generating savings) without reducing service access or quality because: (i) the calculation takes into account historical trends in the use of these services; and (ii) incentivizes use of more cost-effective UPC-funded technologies, resulting in a realignment towards more efficient spending.

1.16 The end-point agreement also includes strategies for centralized procurement of medications, a reinforced national policy on pharmaceuticals, promotion of more efficient handling of orphan diseases[7] and improved management of health care-related services. For more information see optional link 5.

1.17 **Comprehensive Territorial Action Model (MAITE) to improve system efficiency (paragraph 1.12).** The MAITE is a set of actions and tools that, through interagency agreements (national government, territorial entities, EPS, and hospitals) and under department or district-level leadership, direct the coordinated management of health care system entities across the country in order to address the population's priorities, contribute to improved public health, meet citizen expectations and enhance system sustainability. The model includes eight lines of action: governance, financing, insurance coverage, public health, service delivery, tailored offerings, and intersectoral coordination. An assessment specific to each territorial entity breaks down lines of action into action plans with concrete goals to coordinate the work of health care agents and territorial entities around the actions needed to meet health care targets.

1.18 MAITE lines of action for public health and service delivery place particular emphasis on bolstering health promotion and disease prevention services (paragraph 1.11) defined in the Comprehensive Approach to Promoting and Maintaining Good Health provided under Resolution 3280/2018. The document defines population-wide interventions (that affect social and environmental determinants), context-specific collective interventions (in home, community, workplace, educational or institutional settings), and individual, lifecycle-based health care (early childhood, childhood, adolescence, young adulthood, adulthood, older adulthood).

1.19 **Health care for migrants.** The Colombian State has made decisions that seek to facilitate the migrant population's access to health services. MSPS Resolution 3015/2017 establishes the Special Residency Permit as a valid document allowing Venezuelans to enroll in the SGSSS. CONPES 3950 (2018) defined concrete strategies for improving health care services for Venezuelan migrants and their host communities including, among the most relevant: identification of service delivery needs, technical assistance to increase health plan enrollment rates among returnees and Venezuelans with legal status, follow-up appointments for persons without legal status, and enhanced public health sector responsiveness in host communities and territories. In 2018 the MSPS also developed a Health Sector Plan for Responding to the Migratory Phenomenon, which assigned to different levels of

[7] These are serious diseases that threaten the patient's life and affect fewer than 1 in 5,000 persons.

government tasks related to public health management and monitoring, health plan enrollment, and funding. Lastly, Resolution 8470/2019 grants all Venezuelan children born in Colombia after 18 August 2015 (who risk statelessness) the right to enroll in the SGSSS.

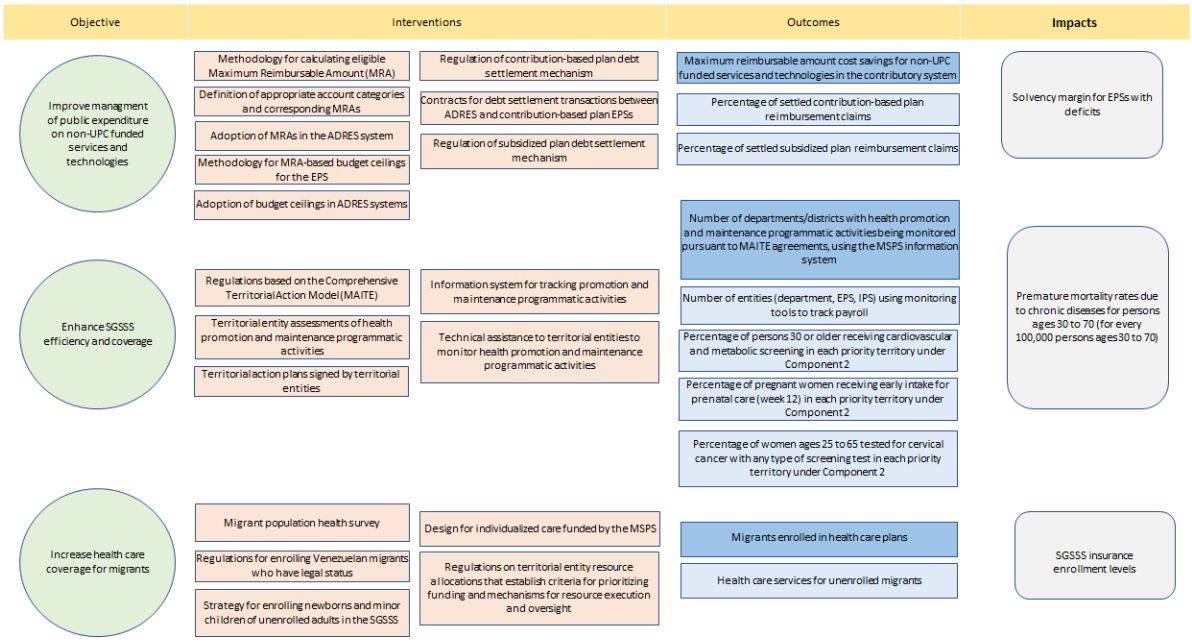
1.20 **Request for support.** The national government requested the structuring of a results-based loan to enhance the effectiveness and efficiency of existing government programs, the end-point agreement, MAITE and the migrant health care policy, thereby targeting concrete, measurable outcomes while also strengthening fiduciary systems, risk management and the governance and management of the national public sector. This results-based loan supports: (i) changes in managing the use of and payment for services not funded under the UPC in order to generate savings that can be reinvested in more cost-effective services; (ii) more efficient management of health care system resources through enhanced health promotion and prevention services; and (iii) sustainable, comprehensive care for migrants through their enrollment in SGSS.

1.21 **Theory of change.** The main problems with the management model for non-UPC financed health care services are: (a) a lack of regulation for a significant percentage of medications that end up being paid for at prices that vary widely and are higher than average prices in comparable countries (Prada, et al. 2018); (b) a lack of control over the total amount paid for services given the absence of a budgetary cap, as with a Health Benefits Plan (the UPC serves as a limit on total spending); and (c) a reimbursement process and denied claims for fair value measurement reasons produce financial imbalances among EPSs and hospitals. Several studies (Proesa, et al., 2016; Acosta, et al., 2014; Silva Illanes, et al., 2017; Bernal, et al., 2017) support price controls, maximum reimbursable amounts and the transfer of risk to strategic buyers with budgets for addressing these types of challenges.

1.22 The dominant health care model in the country lacks sufficient incentives for EPSs and hospitals (Ruiz, et al., 2018) and favors medium and high complexity hospital-based medical care that entails higher costs to the health care system, as opposed to health promotion, disease prevention, and early detection efforts. The main strategy for addressing this situation, backed by extensive literature, is primary health care services, which provide economic benefits by improving the health of the population, increasing health system efficiency and reducing inequalities in health care (WHO, 2018). Evidence suggests that screening and early detection of a variety of conditions in primary care is cost effective. Prioritizing the most appropriate diagnostic test for a given case at the local health care agency, improving territorial planning capacity, and providing data-based monitoring, oversight and feedback on health promotion and disease prevention efforts conducted at local offices are all activities that enhance health care services in medium and low-income countries (Rowe, et al., 2018).

1.23 Lastly, evidence suggests that migrant populations should be enrolled in the formal health care systems provided by host communities (paragraph 1.13) (Meng, et al., 2010, Jalali, 2015; Matlin, et al., 2018; Onarheim, 2018). This reduces service barriers (Pauly & Pagan, 2007, Garfield, et al., 2019), prevents migrants' health conditions from deteriorating and potentially affecting host communities (WHO, 2016, Díaz, et al., 2016), and ensures the flow of resources to service providers (UNHCR, 2012, Moradi-Lakeh & Vosoogh-Mohgaddam, 2015) (see optional link 2).

Chart 1. Program results chain



Note: The results in dark blue are part of the Matrix of Disbursement-lined Indicators.

1.24 **Lessons learned.** The program design incorporates some of the lessons learned from Bank operations to support Colombia and other countries in the region. Component 1 draws on lessons learned from loans 2952/OC-CO and 3248/OC-CO to improve efficiency and equity in SGSSS resource management by promoting the rational use of health care technology. Components 2 and 3 incorporate the following lessons learned: (i) introduce incentives for health care risk management by establishing a performance-based payment mechanism for disease management and prevention (loans 2952/OC-CO and 3248/OC-CO); (ii) incorporate actions to enhance the services network, management, responsiveness and quality of maternal health services and emergency care (loans 3400/OC-BR, 4619/BL-HO, and 4612/BL-BO) with a view to lowering maternal-neonatal mortality rates, especially in vulnerable municipios; and (iii) coordinate health care entities using models tailored to territories' unique characteristics (ATN/OC-13864-CO) in order to improve access to and quality of health services. In the preparation phase, the program design also incorporated lessons learned from implementing other results-based loans (loan 4821/OC-AR), such as the selection of disbursement-linked indicators (DLI) to strike a balance between final and midterm results.

1.25 **Coordination with other multilateral organizations.** The loan forms part of a coordinated and complementary lending arrangement between the IDB and the World Bank for US$300 million, using results-based disbursement instruments aimed at improving the efficiency of the General Social Security Health Care System, as authorized in CONPES document 3976 dated 2 December 2019. The World Bank program focuses on the quality of health care services, system sustainability, and the policy with regard to migrants.

1.26 **Strategic alignment.** The operation is consistent with the Update to the Institutional Strategy (document AB-3190-2) and is strategically aligned with the development challenge of Social Inclusion and Equality by enhancing health services access and quality for all segments of the population. It is also aligned with the crosscutting areas of: (i) gender equality and diversity, by increasing pregnant migrants' access to quality health care services and closing the mortality rate gaps between men and women by providing follow-up care for the percentage of individuals whose health screening indicates risk of cardiovascular disease; and (ii) institutional capacity and rule of law, since it seeks to improve the sustainability, responsiveness, and quality of the country's health care system. It will also contribute to the Corporate Results Framework 2020-2023 (document GN-2727-12) by increasing the number of beneficiaries who receive health services and the number of beneficiaries of initiatives to support migrants and their host communities (444,000 persons). The operation is consistent with the Health and Nutrition Sector Framework (document GN-2735-7) by providing technical assistance and financing for strategies focused on health care system sustainability and strengthening the capacity and management of the services network. It is also consistent with the Gender and Diversity Sector Framework (document GN-2800-8,) by improving access to obstetric care for pregnant migrants, in an effort to reduce maternal and perinatal deaths. Additionally, the operation is aligned with the Country Strategy with Colombia 2019-2022 (document GN-2972) through: (i) strategic objectives to consolidate a sustainable and inclusive pension and health system by controlling spending on high cost services and improving effective access to health services, especially for chronic and communicable diseases; and (ii) regarding the crosscutting immigration issue, increasing the number of Venezuelan migrants registered in the SGSSS (309,072 additional enrollees). The operation was included in the 2020 Operational Program Report (document GN-2991-1). Lastly, it is aligned with the 2018-2022 National Development Plan framework, "Pact for Colombia, Pact for Equity," with the "pact for equity" to ensure the long-term sustainability and inclusiveness of the health care system through efficient access and quality services, in addition to the Health Sector Plan for Responding to the Migratory Phenomenon and CONPES 3950, Strategy for Venezuelan Migration Health Care Services.

B. Objectives, components, and cost

1.27 **Objectives.** Improve SGSSS sustainability in order to consolidate gains made in coverage, equity, financial protection, and improvements to public health. The specific objectives are to: (i) improve management of total spending on non-UPC financed health services and technologies; (ii) improve SGSSS efficiency and coverage; and (iii) increase health coverage for the migrant population.

1.28 **Component 1. Improved expenditure management for non-UPC funded services and technology (IDB Ordinary Capital: US$75 million).** This component seeks to alleviate pressures on public spending stemming from non-UPC funded services and technology, without affecting the quality of services, by supporting implementation of the end-point strategy.[8] Spending will be efficiently managed through: (i) regulation and implementation of a MRA system; (ii) setting of EPS maximum budgets based on the estimated frequency of services and technologies; (iii) transfer of risk and overall management of non-UPC funded technology to EPSs,

[8] ATN/OC-15119-CO supported the MSPS in designing the end-point strategy.

creating incentives for managing high costs in order to redirect spending toward more cost-effective technologies; (iv) settlement of account discrepancies resulting from non-UPC funded technology; (v) regulating payment mechanisms for eligible debts; (vi) recognition and payment of eligible debts; and (vii) tracking and monitoring implementation of a closing accounts mechanism for paid debts. Transfers to EPSs will be partially funded using the MRA or maximum budgets[9] methodology to cover services and technology not financed by the UPC.

1.29 **Component 2. Comprehensive Territorial Action Model - MAITE (IDB Ordinary Capital: US$25 million).** Efficient, effective coverage under the SGSSS would be enhanced by implementing the MAITE[10] which, among other things, promotes greater coordination between the MSPS, territorial entities, service providers, and EPSs in order to enhance basic health promotion and disease prevention services throughout the country.[11] Efficiency and effective coverage in health promotion and disease prevention efforts will increase through: (i) MAITE-based regulations; (ii) territorial entity assessments of health promotion and maintenance programming; (iii) territorial action plans signed by territorial entities (departments and districts) and the MSPS to set health promotion and maintenance targets; (iv) an information system for tracking promotion and maintenance programmatic activities; and (v) technical assistance in territorial entities to monitor health promotion and maintenance programmatic activities. Loan proceeds will cofinance health plan expenses by covering the UPC.

1.30 **Component 3. Insurance coverage and services for the migrant population (IDB Ordinary Capital: US$50 million, IDB Grant Facility: US$9.625 million, PSG (CO-G1019): US$2.100 million).** This component is divided into two subcomponents: (i) insurance coverage for migrants; and (ii) service coverage for the vulnerable migrant population. Subcomponent (i) seeks to improve effective health coverage for migrants as determined in CONPES 3950 on health care services for Venezuelan migrants through the: (i) design and implementation of a migrant population health status survey; (ii) regulations on enrollment processes for Venezuelan migrants with legal status; (iii) design of a strategy for SGSSS enrollment of newborns and minor children of unenrolled adults; and (iv) design and implementation of a strategy for disseminating information among the migrant population about processes for enrolling in and gaining access to health services. Health plan expenses will be partially financed to cover the UPC of SGSSS-enrolled migrants and their children.

1.31 Subcomponent (ii) seeks to improve health care services provided to migrants through: (i) a design for individualized obstetric care using grant funds; and (ii) regulations on resource allocation to territorial entities that defines prioritization criteria and a budget execution and monitoring mechanism. Financing will be provided for obstetric care for the unenrolled migrant population and an audit to verify delivery of those services.

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[9] Once the maximum budget methodology has been implemented, MRAs will serve as reference prices for calculating the maximum budget for each EPS.

[10] ATN/OC-13864-CO supported the design of the Comprehensive Territorial Action Model, the basis for MAITE.

[11] Priority will be given to strategies having the greatest impact on pregnant women and children under 5.

C. Key results indicators

1.32 **Impact and results indicators (Annex II).** At the impact level, indicators on the solvency margin of EPSs running deficits, SGSSS insurance enrollment levels, and premature mortality rates due to chronic diseases (for every 100,000 persons ages 30 to 70) will be measured. Results are expected to include the following DLIs: (i) MRA or maximum budget cost savings for non-UPC funded services and technology under contribution-based plans; (ii) the number of departments or districts with health promotion and disease prevention activities monitored pursuant to MAITE agreements, using the MSPS[12] information system; and (iii) migrant population[13] enrollment rates.[14] Other results indicators include: for contribution-based plans, the percentage of reimbursement claims for non-UPC funded technologies that were submitted as of 31 December 2019 and have been settled; for subsidized plans, the percentage of territorial entity accounts payable for non-UPC technology that were submitted as of 31 December 2019 and have been paid; the number of entities (department, EPS, IPS) using monitoring tools to track payroll; the percentage of persons 30 or older receiving cardiovascular and metabolic screening; the percentage of pregnant women with early intake for prenatal care (week 12); the percentage of women ages 25 to 65 tested for cervical cancer with any type of screening diagnostic; and obstetric care for unenrolled migrants.

1.33 **Cost-benefit analysis** (optional link 1). For Component 1, the cost-benefit ratio, using the monetary values in the results matrix, is 1.19 in the base-case scenario with a 2020-2022 time horizon and discount rate of 3%. Benefits from Components 2 and 3 are directly related to public health and are the result of: (i) a drop in morbimortality--calculated using disability-adjusted life years (DALY)—due to implementation of health care practices with proven effectiveness; and (ii) the monetary conversion of benefits, based on DALY calculations. In the base-case scenario of effective coverage, using a standard gradient vector in which benefits are achieved gradually, with a discount rate of 3% over a three-year time horizon, the cost-benefit ratio for Components 2 and 3 is 1.19. Additionally, sensitivity analyses over a 6-year time horizon reflect a cost-benefit ratio that is greater than one, under almost all scenarios. In the base-case scenario, the internal rate of return is 45.5%.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 **Disbursement amounts and schedule**. This is a results-based loan program totaling US$161,835,900, of which US$150 million will be from the Bank's Ordinary Capital, US$9,625,000 from the IDB Grant Facility to support countries with large and sudden intraregional migration inflows and US$2,210,900 from a project-specific grant funded by BMZ (CO-G1019).[15] After deducting the administration fee of US$110,545, the total amount available for the program is US$161,725,355. As

[12] The information system will use Individual Health Care Services Records (RIPS) for specific monitoring of health promotion and disease prevention programmatic activities.

[13] Includes migrant children born in Colombia.

[14] Shared with the World Bank. IDB funding provides resources to achieve 47% of this target.

[15] The exchange rate is available on the Bank's Finance Department website.

shown in Table 2.2, the program will have a three-year disbursement period, which reflects government financing needs.

Table 2.1. Estimated program costs (in US$ millions)

Components	IDB Ordinary Capital (CO-L1248)	IDB Grant Facility (CO-J0011)	BMZ PSG (CO-G1019)	Total	%
1. Improved expenditure management for non-UPC funded services and technology	75	-	-	75	46.4
2. Comprehensive Territorial Action Model (MAITE)	25	-	-	25	15.4
3. Insurance coverage and services for the migrant population	50	9.625	2.100	61.725	38.2
3(i). Insurance coverage for the migrant population	50	-	-	50	31
3(ii). Health care coverage for the migrant population	-	9.555	2.100	11.655	7.2
Audits of grant funds	-	0.070	-	0.,070	0.04
Total available for the project	**150**	**9.625**	**2.100**	**161.725**	**100**
Administration fee—BMZ resources	-	-	0.110	0.110	
Total	**150**	**9.625**	**2.210**	**161.835**	

Table 2.2. Disbursement schedule and tranches (in US$ millions)[16]

Components	Year 1	Year 2	Year 3	Total
1. Improved expenditure management for non-UPC funded services and technology	17.5	17.5	40	75
2. MAITE	7.5	7.5	10	25
3(i). Insurance coverage for the migrant population	25	25	-	61.725
3(ii). Health care coverage for the migrant population	5.862	5.863	-	
Total available for the project	**55.862**	**55.863**	**50**	**161.725**

2.2 **Rationale for a results-based loan.** The results-based loan was structured in such a way that its components meet the requirements specified in document GN-2869-3, by: (i) addressing challenges identified in the diagnostic assessment, such as more robust SGSSS spending oversight, strengthening MSPS capacity to deliver timely health promotion and disease prevention services, and responding to challenges posed by sudden, massive migration; (ii) enhancing performance in programs related to end-point agreements (paragraph 1.14), MAITE (paragraph 1.17), and health policy for the migrant population (paragraph 1.19), focused on achieving results; and (iii) promoting use and strengthening of the executing agency's fiduciary systems, with results-based loan principles and good practices and in accordance with the institutional capacity analysis, which found that systems are available to ensure proper technical and fiduciary execution of the program. The DLIs reflect a logical sequence for achieving the ultimate objective of the project by strengthening country systems and achieving midterm and final results.

2.3 **Rationale for grant funds**. Unparalleled migration flows pose a new challenge for the countries of Latin America and the Caribbean, with the potential to negatively

[16] Health care related disbursements stemming from the COVID-19 pandemic are not projected to slow down. On the contrary, government requests for disbursements have the potential to accelerate if funding needs increase in 2021.

impact host communities if not addressed adequately and urgently. To deal with these exceptional circumstances, the Board of Governors of the IDB approved the use of up to US$100 million in available Ordinary Capital funds through the IDB Grant Facility to support countries with large and sudden intraregional migration inflows (documents GN-2947-6 and AB-3199). The Grant Facility seeks to help countries design interventions so migrants and host communities can gain access to basic services, social services, and economic opportunities that benefit both migrants and the local population, thereby supporting inclusive development and fostering a positive relationship between the two communities.

2.4 Component 3 of the program satisfies the five eligibility criteria for use of the Grant Facility. The migration annex (optional link 4) provides details on compliance, which are summarized below. First, the number of migrants Colombia received between 2016 and 2018 was equivalent to 2.3% of its population. Second, this is a large, sudden inflow in which: (i) most migrants are not enrolled in the SGSSS and access health care through high-cost, under-funded emergency services; (ii) there is growing demand for health care services because of the collapse of the Venezuelan health system; and (iii) migrant populations are becoming concentrated in certain areas where the public health situation is significantly lagging. The component seeks to improve the migrant population's access to insurance coverage and health care services. Third, since this is an operation to improve health care coverage, it is consistent with the focus on access to social services. Fourth, the operation's results matrix sets targets for medical care provided to migrants and specifies targeting criteria to ensure compliance. Fifth, the operation was part of 2020 programming.

2.5 BMZ funding will be received through a project-specific grant, which the Bank will administer pursuant to the "Report on COFABs, Ad-Hocs and CLFGs and a Proposal to Unify Them as Project Specific Grants (PSG)" (document SC-114). The BMZ commitment will be established through an administration agreement without the need to prepare or approve a separate project proposal. Under the agreement, funds contributed by the donor will be administered by the Bank, which will charge a nonrefundable administration fee equivalent to 5% of the contribution. This fee will become payable once the Bank has received the contribution. Accordingly, the Board of Executive Directors is requested to authorize the Bank's President, or a representative designated by him, to sign the necessary agreements with the BMZ and the Republic of Colombia to receive, administer, and allocate to this operation the proceeds of the aforementioned financing for the purpose of supporting and executing the program.

B. Environmental and social safeguard risks

2.6 This program falls under Directive B.13 of the Bank's Environment and Safeguards Compliance Policy (operational policy OP-703) because it is a results-based loan. No environmental or social risks or impacts were identified, either moderate or high, as the project does not entail investment in infrastructure or relocation of communities and seeks instead to lower barriers to health care access for the migrant population.

C. Fiduciary risks

2.7 The institutional capacity assessment found that the MSPS and ADRES have a high ability to execute the operation. However, the program's fiduciary risk is high due to

the technical complexity of execution, the involvement of external actors, and the sensitive nature of health care issues for the Government of Colombia. The following fiduciary risks were identified: (i) difficulty in identifying the execution of loan resources in the ADRES accounting and financial system, for accountability purposes, and (ii) the possibility of the Comptroller General of the Republic issuing a qualified opinion about ADRES financial statements.

2.8 To mitigate the first risk: (i) ADRES will include a note in its financial statements indicating execution of the loan proceeds for each component; and (ii) the MSPS will conduct accounting and financial oversight to monitor the execution and accounting classification of disbursed funds under each category related to compliance with results indicators. To mitigate the second risk: (i) methodology for the UPC payment will change and advances to EPSs will be eliminated; and (ii) in the National General Budget for 2020, the Ministry of Finance and Public Credit (MHCP) will include in the MSPS Annual Program for Monthly Payments from Cash Flow resources in liquidation that correspond to accounts receivable from the Social Security Institute.

D. Other key issues and risks

2.9 **Risks.** Medium-high level risks related to public management and governance:

a. If lawsuits are filed because of articles of the National Development Plan related to MRAs or maximum budgets, courts could find for the plaintiffs and the Ministry would lose its autonomy to set MRAs or maximum budgets, which would delay compliance with DLI 1 (MRA savings in the contribution-based system) by up to one year. There are plans to develop and implement a strategy for a robust defense of the legal grounds for these mechanisms and for MRAs to be replaced directly with price controls as a mechanism for achieving the expected savings required for compliance with DLI 1.

b. At the beginning of the project, staff turnover among those working on the design and implementation of the system for tracking and monitoring health promotion and disease prevention activities could impact the tool's conceptual design and development, delaying initial implementation by six months to a year (output 2.4), which would impact the disbursement target beginning in the first year. It is anticipated that, in order to ensure the program's continuity in the MSPS, positions, manuals, responsibility levels and required procedures will be developed during the process of consolidating the project and its programs within the MSPS functional and operational structure.

c. If territorial entities, insurers, and service providers lack incentives for enrolling migrants in health care plans, they could set up barriers to the enrollment process, having a 20%-30% effect on the total enrollment target for outcome 9 and the disbursements target. Plans are underway to develop strategies to simplify the enrollment process by using public hospitals and disseminate information about enrollment pathways.

2.10 Development risk is classified as medium-high:

a. If the current capacity for data processing and storage under the MSPS Information System (SISPRO) is limited, implementing the system for tracking and monitoring health promotion and disease prevention activities could surpass existing capacity into the second year of the program, which would

affect the number of entities (departments, EPS, IPS) using the tool and delay access for a year. It is anticipated that a plan will be agreed upon to enhance or expand the system's capacity for data processing, storage, and retrieval to meet application requirements.

2.11 **Sustainability.** The proposed interventions align with government strategies to promote SGSSS sustainability. Also, program resources are a small percentage of the government's own resources for managing non-UPC funded services (Component 1) and health care coverage expenditures both for the general population (Component 2) and migrant population (Component 3), so replacing this funding source will not represent a financing issue. Additionally, lessons learned from the program will allow for more efficient management of SGSSS funds.

III. Implementation and Management Plan

A. Summary of implementation arrangements

3.1 **Borrower and executing agency.** The borrower and beneficiary is the Republic of Colombia, and the executing agency will be MSPS which, through transfers to ADRES, will execute loan proceeds. MSPS will also execute the grant funds.

3.2 **Coordination among actors.** The MSPS Sector Financing Office (DFS) will coordinate regular meetings to ensure progress in executing the program's various programming areas. Project planning and execution will be done with technical teams from the agencies and offices involved in coordinating and reporting on MSPS program components, and those teams will work in conjunction with the ADRES Office for Health Care Finance Management.

3.3 **Program administration.** Planning of activities under each component will be consistent with the government strategy for SGSSS sustainability. The various agencies involved in the regular meetings will coordinate program monitoring and oversight. The goal is for DFS to monitor program developments, produce reports on execution, and request Bank disbursements. Additional details on areas of responsibility, the role of each technical group and information flow for reporting on results will be described in optional link 2. The relationship between the MSPS and ADRES is regulated by national law.

3.4 **External verification of results.** The National Planning Department (NDP), a public entity that is independent from the executing agency and specifically mandated to do outcome and impact assessments on the government's main programs, will conduct an external, independent assessment of DLI targets. The NDP has extensive experience in evaluating and monitoring projects, working with results indicators, and assessing information sources. According to the OECD (2014), the NDP possesses "one of the most advanced systems in the world for monitoring overall government performance." It meets the requirements for assessing the outcomes of this program because of its advanced technical capabilities and credibility in evaluating program results (paragraph 2.14 of the guidelines in document GN-2869-3). The review will produce a timely assessment of results prior to each request for disbursement. Verification process activities will include: (i) determining the accuracy, reliability, and consistency of data used in DLI results; and (ii) reporting DLI results for each disbursement tranche. The monitoring and evaluation plan (required link 1) describes the protocol for verifying each DLI.

3.5 **Flow of resources.** Ordinary Capital funds for the program will follow the process established in the National General Budget for SGSSS financing. The MSPS, during the first quarter of each year, will prepare a preliminary draft budget that includes the SGSSS budget. Once the Ministry of Finance and Public Credit (MHCP) approves the draft budget, the MSPS will submit an authorization request for the ADRES Office of Health Care Finance Management (DGRFS) to execute the resources for health care coverage in monthly installments. Grant Facility and PSG funds will follow the flow of resources for government public investment projects.

3.6 **Disbursements.** A special dollar account will be opened in the name of the program, at the financial institution specified by the Ministry of Finance and Public Credit, for each financing instrument (loan, grant, and PSG). The program operating manual will provide details on different aspects of program execution, including the responsibilities of the offices involved.

3.7 **Execution of grant funds.** The MSPS will execute grant funds through an investment project. The program operating manual will define the mechanism for executing the funds.

3.8 **Special contractual conditions precedent to the first disbursement of the loan proceeds. The executing agency will submit evidence that it has approved the program operating manual and that the manual has entered into force, under terms previously agreed upon with the Bank.** This condition is essential to begin implementing program components and ensure proper program execution.

3.9 **Program operating manual (optional link 2).** The program operating manual will outline a strategy for program execution, including: (i) program organizational chart; (ii) technical and operational arrangements for execution; (iii) mechanism for programming and monitoring and evaluating results; and (iv) a detailed description of results indicators, DLIs, and their verification protocols. The program operating manual includes the criteria for external verification of program results.

3.10 **External audit.** For the loan, the Bank will accept ADRES financial statements audited by a Bank-acceptable independent audit firm, and audit services may be financed with loan proceeds. Consolidated financial statements for Grant Facility and PSG resources will be audited annually by a Bank-acceptable independent audit firm, and the audit will be financed with grant funds. The engaging of auditing services will follow procedures and terms of reference previously agreed upon with the Bank. Audited financial statements for each instrument will be submitted to the Bank within 120 days of the closing of each MSPS fiscal period during the original disbursement period or its extensions. The final audited financial statement for each instrument will be submitted within 120 days of the date of the last disbursement.

B. Summary of arrangements for monitoring results

3.11 **Monitoring arrangements.** The executing agency and the Bank have agreed to closely monitor program execution using the Results Matrix (Annex II), a verification protocol for each DLI that provides its definition, compliance criteria, timeline, funding sources, semiannual progress reports, and supervision visits. The MSPS will submit a monitoring report to the IDB, within 60 days of the end of each calendar half-year. The monitoring and evaluation plan provides further details (required link 1). Additionally, the project team will be responsible for preparing and submitting the project report to the donor. If, at the end of project execution, there is an unspent,

unappropriated balance, the project team will be responsible for informing the Grants and Co-Financing Management Unit (ORP/GCM) so it may transfer the balance of funds as agreed upon with the donor and Bank, pursuant to the terms of the PSG administration agreement.

3.12 **Arrangements for evaluating results**. The strategy for program evaluation is divided into four parts. For Component 1, the objective of the evaluation is to establish if the savings generated, when considered in terms of monetary benefits, surpass component expenditures. The evaluation methodology involves an ex post monetary cost-benefit analysis to be done at the end of the disbursement period for the loan (2022), complemented by a qualitative analysis based on semistructured interviews of key actors among the MSPS and EPS management. Component 2 will evaluate the evolution of results indicators selected before and after the program, complemented by semistructured interviews with management at the various entities (departments, EPS, IPS) and key actors involved in implementing MAITE. Component 3 involves a mixed methodology based on a before and after assessment of the indicator related to migrant population health plan enrollment and a qualitative analysis of barriers to effective coverage in terms of health care access for the enrolled migrant population (monitoring and evaluation plan and required link 1).

Development Effectiveness Matrix		
Summary	**CO-L1248**	
I. Corporate and Country Priorities		
1. IDB Development Objectives		
Development Challenges & Cross-cutting Themes	**-Social Inclusion and Equality -Gender Equality and Diversity -Institutional Capacity and the Rule of Law**	
Country Development Results Indicators	**-Beneficiaries receiving health services (#)***	
2. Country Development Objectives		
Country Strategy Results Matrix	**GN-2972**	**Through the strategic objective to consolidate a sustainable and inclusive pension and health system; improving service qulity and access.**
Country Program Results Matrix	**GN-2991-1**	**The intervention is included in the 2020 Operational Program.**
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		**Paragraph 1.22**
II. Development Outcomes - Evaluability		**Evaluable**
3. Evidence-based Assessment & Solution	**10.0**	
3.1 Program Diagnosis	**3.0**	
3.2 Proposed Interventions or Solutions	**4.0**	
3.3 Results Matrix Quality	**3.0**	
4. Ex ante Economic Analysis	**10.0**	
4.1 Program has an ERR/NPV, or key outcomes identified for CEA	**3.0**	
4.2 Identified and Quantified Benefits and Costs	**3.0**	
4.3 Reasonable Assumptions	**1.0**	
4.4 Sensitivity Analysis	**2.0**	
4.5 Consistency with results matrix	**1.0**	
5. Monitoring and Evaluation	**8.5**	
5.1 Monitoring Mechanisms	**2.5**	
5.2 Evaluation Plan	**6.0**	
III. Risks & Mitigation Monitoring Matrix		
Overall risks rate = magnitude of risks*likelihood	**Low**	
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/FMP Criteria)	**Yes**	**Financial Management: Budget, Treasury, Accounting and Reporting, External Control. Procurement: Information System, Price Comparison, Contracting Individual Consultant.**
Non-Fiduciary	**Yes**	**Monitoring and Evaluation National System.**
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:		
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**	**It wil be supported through technical cooperation CO-T1517**

Note: (*) Indicates contribution to the corresponding CRF's Country Development Results Indicator.

The Program to Improve the Sustainability of the Health System in Colombia with an Inclusive Approach aims to improve the sustainability of the SGSSS, preserving the achievements in coverage, equity and financial protection, and improving the health of the population. The program has three specific objectives (1) to improve the management of the total cost of health services and technologies not financed with the Capita Payments (UPC) (2) to improve the efficiency and coverage of the General System of Social Security in Health (SGSSS) and (3) to increase health coverage for the migrant population. The loan proposal presents a solid diagnosis of the sustainability challenges in the health system in Colombia. The results matrix includes SMART indicators at the level of impacts, outcomes and outputs, and the achievement of each specific objective will be measured with at least one indicator. The economic analysis of the project is based on cost-efficiency analysis for component 1 and cost-benefit analysis for components 2 and 3. The monitoring and evaluation plan includes a detailed description to guide the construction of the Indicators Linked to Disbursement (IVD) as well as impact indicators and other outcome indicators. The National Planning Department (DNP) will verify the IVD and the Executing Agency will be responsible for the other monitoring and evaluation activities of the Program. In the absence of an impact evaluation, the attribution analysis will include an ex-post efficiency analysis for component 1, and a mixed-methods analysis with before and after comparison of results supplemented with qualitative evaluation for components 2 and 3.

RESULTS MATRIX

Objective:	Improve the sustainability of the General Social Security Health Care System (SGSSS) to consolidate gains in coverage, equity, and financial protection, together with health improvements for the general population. The specific objectives are to: (i) improve management of total expenditures on health-related services and technology not funded through Per Capita Payment Units (UPC); (ii) enhance SGSSS efficiency and coverage; and (iii) increase health care coverage for the migrant population.

EXPECTED IMPACT

Indicators	Unit of measure	Baseline		End of project		Means of verification
		Amount	Year	Amount	Year	
1. Solvency margin of EPSs running deficits	Trillion of pesos	-7.3	2017	-5.0	2022	Monitoring report on long-term financial stability indicators on EPS from the National Health Superintendency
2. SGSSS enrollment coverage	Percentage	95.07	2019	96	2022	MSPS Single Database of the Insured Population
3. Premature mortality rates due to chronic diseases in persons ages 30 to 70 (for every 100,000 persons ages 30 to 70)	Deaths per 100,000 residents	230.57	2016	227.5	2022	Vital statistics from DANE and number of deaths recorded per MSPS.

EXPECTED OUTCOMES

Expected outcomes	Unit of measure-ment	Baseline		Year			End of project	Means of verification	Disbursement-linked indicator
		Amount	Year	1	2	3			
1. Savings from maximum reimbursable amount or maximum budget for non-UPC funded services and technologies under the contribution-based system	Billions of Col$	0	2018	20	150	250	250	Social Security Health Care Resource Administration (ADRES) database on reimbursements, following standardization by MSPS National Regulatory Agency for Health Care Insurance Benefits, Costs, and Fees	Yes
2. Percentage of settled reimbursement claims for non-UPC funded technology under the contribution-based system	Percentage			25	50	75	100	ADRES report using database created once asset/liability determination performed under the end-point agreement.	No

Expected outcomes	Unit of measure-ment	Baseline		Year			End of project	Means of verification	Disbursement-linked indicator
		Amount	Year	1	2	3			
3. Percentage of subsidized system territorial entity accounts payable (for non-UPC funded technology) submitted and paid as of 31 December 2019				20	40	60	60	Report on the end-point agreement execution prepared by the MSPS Sectoral Financing Office	
4. Number of departments or districts with health promotion and maintenance programmatic activities being monitored pursuant to MAITE agreements, using the MSPS[1] information system	Number of depart-ments or districts	0	2019	2	5	10	10	National Planning Department verification report on the disbursement indicator, including: MSPS quarterly report on programmatic activities and quarterly monitoring report for each territorial entity.	Yes
5. Number of entities using monitoring tools to track payroll	Number of entities (EPS and IPS)			6	15	30	30	Report on implementation of MSPS monitoring tool to track payroll.	No
6. Percentage of persons 30 or older in each territory prioritized under Component 2 receiving cardiovascular and metabolic screening	Percentage in each territory	1.67%***	2018	5%	10%	40%	40%		No
7. Percentage of pregnant women receiving early intake for prenatal care (week 12) in each priority territory under Component 2		24.51%***		-	40%	50%	50%		
8. Percentage of women ages 25 to 65 tested for cervical cancer with any type of screening diagnostic in each priority territory under Component 2		20.22%***		25%	30%	50%	50%		

[1] The information system will use Individual Health Care Service Records for specific monitoring of health promotion and maintenance programmatic activities.

Expected outcomes	Unit of measure-ment	Baseline		Year			End of project	Means of verification	Disbursement-linked indicator
		Amount	Year	1	2	3			
9. Migrants[2] enrolled[3] in health care plans	Number	115,928	2019	220,000	320,000	425,000	425,000	MSPS Single Database of the Insured Population	Yes
10. Obstetric care for unenrolled migrants	Number	0	2018	-	9,500	9,500	19,000	MSPS report based on the payment auditing process.	No

*** Initial calculation subject to adjustments once the monitoring tool has been developed and deployed based on Individual Health Care Service Records.

DISBURSEMENT-LINKED INDICATORS (US$ MILLION)

Expected Outcomes	Year 1			Year 2			Year 3			Total amount
	TARGET	AMOUNT	SOURCE	TARGET	AMOUNT	SOURCE	TARGET	AMOUNT	SOURCE	
1. Savings from maximum reimbursable amount or maximum budget for non-UPC funded services and technologies under the contribution-based system (billions)	Col$20	17.5	Ordinary Capital	Col$150	17.5	Ordinary Capital	Col$250	40	Ordinary Capital	75
2. Number of departments or districts with health promotion and maintenance programmatic activities being monitored pursuant to MAITE agreements, using the MSPS[4] information system.	2	7.5	Ordinary Capital	5	7.5	Ordinary Capital	10	10	Ordinary Capital	25
3. Migrant population[5] enrolled[6] in health insurance	220,000	25	Ordinary Capital	320,000	25	Ordinary Capital	-	-	-	50
		-	-		5.862*	GRF/PSG**		5.863*	GRF/PSG**	11.725
Total		50			55.862			55.863		161.725

* This corresponds to US$4,812,500 from the Grant Facility and US$1.05 million from the PSG.

** The Grant Facility and PSG funds will be disbursed at the beginning of the year subsequent to the target being met.

2 Includes children born in Colombia to migrant parents.

3 Shared in IDB and World Bank loan programs. IDB financing provides 47% of the loan proceeds for this target.

4 The information system will use Individual Health Care Service Records for specific monitoring of health promotion and maintenance programmatic activities.

5 Includes children born in Colombia to migrant parents.

6 Shared in IDB and World Bank operations. IDB financing provides the financing to achieve 47% of this target.

OUTPUTS[7]

Outputs	Unit of Measurement	Baseline		Year			Target
		Amount	Year	1	2	3	
Component 1: Improved expenditure management for non-UPC funded services and technology							
1.1. Methodology for calculating MRAs and MSPS payments for services and technologies not funded under the Per Capita Payment Unit (UPC)	# Methodologies	0	2018	1	0	0	1
1.2. Definition of appropriate cost categories (with their MRAs) for MSPS recognition and payment for non-UPC funded services and technologies	# Lists			2	0	0	2
1.3. Adoption of MRAs in ADRES systems	# System		2019	1	0	0	1
1.4. Methodology for MRA-based maximum budgets for the EPS	# Methodologies			1	0	0	1
1.5. Adoption of maximum budgets in ADRES systems	# System			0	1	0	1
1.6. Regulations for Article 237 of the Development Plan Act to define mechanisms for settling debts resulting from non-UPC funded services and technology under the contribution-based system	# Decree	0	2019	1	0	0	1
1.7. Signed contracts for EPS and ADRES transactions to settle debts related to non-UPC funded services and technology under the contribution-based system	Number			0	4	6	10
1.8. Regulations for Article 238 of the Development Plan Act to define mechanisms for assessing territorial entities' fiscal efforts and the country's cofinancing to settle debts stemming from non-UPC funded services and technology under the subsidized system	Number			1	0	0	1
Component 2: Comprehensive Territorial Action Model - MAITE							
2.1. Regulations establishing the MAITE	# Resolution	0	2018	1	0	0	1
2.2. Territorial entity assessments of health promotion and maintenance programmatic activities	# Diagnostic tests	0	2019	2	5	10	10
2.3. Territorial action plans signed by territorial entities and the MSPS to set targets for health promotion and maintenance programmatic activities	Number	0	2019	2	5	10	10
2.4. Information system for tracking promotion and maintenance programmatic activities	# System			1	0	0	1
2.5. Technical assistance in territorial entities to monitor health promotion and maintenance programmatic activities	Number of territorial entities			2	5	10	10
Component 3: Insurance coverage and services for the migrant population							
3.1. Migrant population health status survey	Number	0	2018	1	0	1	2
3.2. Regulations for enrolling Venezuelan migrants with legal status	# Decree					0	1
3.3. Strategy for enrolling newborns and minor children of unenrolled adults in the SGSSS	Number					0	1

[7] Complete detailed descriptions of the verification sources for each output are in the results matrix of the monitoring and evaluation plan (required link 1).

Outputs	Unit of Measurement	Baseline		Year			Target
		Amount	Year	1	2	3	
3.4. Implementation of a strategy for disseminating information among the migrant population about processes for enrolling in and gaining access to health services	Number	0	2019	1	-	-	1
3.5. Design for individualized obstetric care to be financed with grant resources	# Document			1	0	0	1
3.6. Regulations on territorial entity resource allocations that establish the criteria for prioritizing funding and mechanisms for resource execution and oversight	# Resolutions			0	1	1	2

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Colombia
Project number:	CO-L1248, CO-J001, and CO-G1019
Name:	Program to Enhance Sustainability and Inclusiveness in the Colombian Health Care System
Executing agency:	Ministry of Health and Social Protection (MSPS)
Prepared by:	Mylenna Cárdenas, Financial Management Specialist and Eugenio Hillman, Lead Procurement Specialist (VPC/FMP)

I. EXECUTIVE SUMMARY

1.1 The borrower is the Republic of Colombia, and the executing agency of the results-based loan (RBL) is the Ministry of Health and Social Protection (MSPS) through the Social Security Health Care Resource Administration (ADRES), which reports to the MSPS. The ADRES has an Office for Health Care Finance Management (DGRFS), which will be responsible for program treasury operations.

1.2 An institutional capacity assessment of the MSPS and ADRES was performed using the Institutional Capacity Assessment Platform. The assessment focused on those agencies that will participate in program execution, and it included a review of the process for integrating the MSPS and ADRES financial data systems and processes for planning, budgeting, goods and services procurement, disbursements, treasury, accounting, and monitoring. Fiduciary systems were assessed based on guidelines for preparing RBL operations. The institutional capacity assessment found that the MSPS and ADRES have a **high** capacity to execute the operation, but the program's fiduciary risk is **high** due to the complexity of implementation arrangements, the involvement of external actors, and the sensitive nature of health care issues for the Government of Colombia. For this reason, the MSPS should designate an office and responsible employee assigned part-time to track and monitor compliance with indicators and coordinate operations related to Bank requirements. The program operating manual will also define the relationship between the MSPS and ADRES and their corresponding program execution responsibilities.

1.3 According to the PEFA[1] assessment and Guidelines for Determining Development Level and Use of the Public Finance Management System (GUS), Colombia has a public finance management system that is mature and performs well in most areas but is still not fully aligned with international standards. Based on implementation of the GUS, the Bank validated the treasury, budgeting, accounting and reporting systems to be used for the program. Furthermore, based on MAPS[2] assessment results and the Guide for Acceptance of Use of Country Procurement Systems, from a regulatory standpoint Colombia's Public Procurement System is adequate and consistent with internationally accepted practices and has been authorized for use with Bank financing.

[1] Public Expenditure and Financial Accountability.

[2] Methodology for Assessing Procurement Systems.

1.4 The amount financed includes US$150 million from the Bank's Ordinary Capital, US$9,625,000 from the IDB Grant Facility and US$2.21 million from a PSG funded by the BMZ (CO-G1019) to support Component 3. After deducting the administration fee (US$110,545), the total amount available for the program is US$161,725,355. The program has a three-year disbursement period and does not include a local contribution. The World Bank is expected to provide US$150 million in financing.

II. THE EXECUTING AGENCY'S FIDUCIARY CONTEXT

2.1 Program resources will be part of the National General Budget. Loan execution will be conducted through the MSPS operating fund for health care insurance coverage, while the nonreimbursable funds (Grant Facility and PSG) will be executed through an investment project. Accordingly, independent records for each funding source will be kept in the Integrated Financial Information System (SIIF). The MSPS will coordinate the financial and administrative procedures for the loan and grant funds (budget, disbursement requests, general accounting, and submission of financial statements to the Bank) and will be responsible for procurement and contracting processes, specifically those involving grant resources. Loan proceeds will be deposited with the MSPS, which will authorize their transfer to ADRES for execution. ADRES will perform the treasury function for payments required for executing the three components of the loan that are part of the MSPS budget for health care insurance coverage. For purposes of Component 3.2, the MSPS will execute the grant funds directly.

2.2 In terms of strengths, the MSPS has an Integrated System for Quality Management capable of providing oversight and making resources available to achieve the expected outcomes both for the Ministry and its investment projects. Likewise, the MSPS and ADRES each have an Office of Internal Oversight and document management processes for proper traceability of the documents they produce and process. Nonetheless, ADRES oversight mechanisms are not effective in mitigating all its risk, so it has begun an upgrade and has developed an improvement plan that incorporates actions needed to strengthen those areas.

III. FIDUCIARY RISK EVALUATION

3.1 Program fiduciary risks:

Type	Risk	Level	Mitigation Actions
Accountability	Difficulty identifying loan resource execution in the ADRES accounting and financial system for accountability purposes.	High	- ADRES will include a clarification in the financial statement notes to indicate, by component, the execution of loan resources. - The MSPS will perform accounting and financial audits to monitor the execution and accounting classification of disbursed funds for each category linked to compliance with results indicators.
Financial management	Possibility of the Comptroller General of the Republic (CGR) issuing a qualified opinion on ADRES financial statements.		Address the caveats: - Change the methodology for UPC payments and eliminate the payment of advances to EPSs. - In the country's 2020 National General Budget, the MHCP will include in the MSPS annual cash flow program, funds in liquidation under accounts receivable from the Social Security Institute.

IV. Considerations for the Special Provisions of Contracts

4.1 For the grant funds, the MSPS will use the U.S. dollars to Colombian pesos exchange rate. No exchange rate is defined for the loan because it will be accounted for in pesos.

4.2 For purposes of accounting for the grant funds and for the SIIF to automatically generate consolidated financial statements, the MSPS will request that a program chart of accounts be developed and that it include the two funding sources so it may be parameterized according to the component categories and fund distribution established in the "Costs and Financing" table in the Single Annex to the Agreements.

4.3 Annually until the conclusion of the program, the MSPS will submit, within 120 days of the closing of each year, audited ADRES financial statements for the loan proceeds and audited consolidated financial statements for the nonreimbursable funds.

V. Agreements and Requirements for Procurement Execution

A. Procurement execution

5.1 Pursuant to document GN-2869-1, paragraph 5.34, the Bank's Policies for the Procurement of Goods and Works (document GN-2349-9) and the Policies for the Selection and Contracting of Consultants (document GN-2350-9) do not apply to RBL projects. The Board of Executive Directors has approved an exception regarding the origin of goods and the nationality of companies and individuals related to an IDB member state.

5.2 Since this is an RBL, program procurement will use the executing agency's own procurement and contracting systems. The external audit of grant proceeds will be commissioned in accordance with Bank policies and procedures.

B. Use of the executing agency's procurement system

5.3 The MSPS and ADRES procurement system is provided for under Law 80 and Decree 1150 and the Bank evaluated, approved, and deemed it compatible with internationally accepted principles, practices, and standards.

C. Main procurements

5.4 It is not anticipated that the executing agency, which will execute funds as part of its operations under the health care insurance system, will use loan proceeds for procurement.

5.5 **Procurement supervision:** Given the nature of this loan program, the Bank will not conduct procurement reviews. For the technical cooperation, procurements will be reviewed ex ante, and audits will provide additional oversight.

5.6 **Records and files:** The MSPS and ADRES will preserve all program documents and records, especially those that support fiduciary management, for a period of at least 20 years as of the end of the contract period or contract liquidation, as required. The Contract Management Group and the Contract Execution and Liquidation Group will be responsible for maintaining project fiduciary documentation, each according to its area of jurisdiction, as shall the Document Administration Group of

the General Secretariat, once document preservation terms have expired for the respective management files.

VI. FINANCIAL MANAGEMENT

6.1 **Programming and budget:** The national government, through the National Budget Administration and National Planning Department, is responsible for budget programming, a process that includes Congress's approval of the Annual Budget Law. Program funds will be included in the National General Budget under the MSPS categories and using the SIIF. Loan proceeds will be included in the National Budget under the health insurance category (code 10, which will be replaced by code 14 in effect for 2020), and Grant Facility and PSG funds will be recorded as an investment project financed with donor resources (code 15). No budgetary issues are expected.

6.2 **Accounting and information systems:** The public accounting regulatory agency in Colombia is the General Accounting Office (CGN), which provides guidelines on proper accounting processes for entities included in the National General Budget. The MSPS will use the SIIF to monitor the program's budgetary, accounting, and treasury operations and will execute the project budget through fund transfers to ADRES. Additionally, the MSPS will make an accounting record of this process in memoranda accounts using the causation method and will perform accounting and financial audits to monitor the execution and accounting classification of disbursed funds in each of the categories linked to compliance with results indicators.

6.3 The ADRES will conduct accounting activities in accordance with the General Plan on Public Accounting and CGN accounting principles, regulations, interpretations, and guidelines for public accounting. ADRES accounting policies are consistent with Accounting and Financial Information Standards accepted in Colombia and with the instructions and practices of the Financial Superintendency of Colombia. Using the causation method, ADRES will enter accounting records for the loan proceeds into its accounts system, Microsoft Dynamics AX2012 ERP, which is a multi-user platform. The system has three modules (budget, treasury, and accounting) and generates a monthly report, sent to MSPS, on ADRES payments to EPSs using funds allocated for health insurance.

6.4 For the loan, the Bank will accept ADRES basic financial statements, which are prepared in pesos and use the causation method since they involve execution of loan proceeds. An explanatory note must be included with financial statements and indicate the funds used for each component.

6.5 For the Grant Facility and PSG, the MSPS will prepare consolidated project financial statements for these funds, in dollars and using cash basis accounting, and this will require SIIF to create a single sub-unit to differentiate financing. The SIIF will generate the consolidated financial statements automatically.

6.6 **Disbursements and cash flow:** A special dollar account for each funding instrument (loan, Grant Facility and PSG) will be opened at a financial institution to be designated by the MHCP. The MSPS will prepare disbursement requests to be presented to the MHCP, which the MHCP then will submit to the Bank. Disbursement requests for Grant Facility and PSG funds will be presented by the MSPS directly to the Bank. The MSPS will submit requests for the MHCP to transfer loan resources to ADRES, which will be responsible for treasury management, and

funds will be deposited into the ADRES general account for managing MSPS-allocated health care resources. The Bank will make disbursements in dollars based on compliance with the indicators stipulated for each component, both for the loan and Grant Facility resources. There will be no advances or retroactive funding. The estimated funding flow is shown below in U.S. dollars:

Execution Years	2020	2021	2022	Cumulative
Undisbursed balance	**161,725,355**	**111,725,355**	**55,862,678**	**0**
Disbursements	**50,000,000**	**55,862,677**	**55,862,678**	**161,725,355**
Loan	50,000,000	50,000,000	50,000,000	150,000,000
Grant Facility	0	4,812,500	4,812,500	9,625,000
PSG	0	1,050,177	1,050,178	2,100,355
Funding execution	**50,000,000**	**55,862,677**	**55,862,678**	**161,725,355**
Component 1	17,500,000	17,500,000	40,000,000	75,000,000
Component 2	7,500,000	7,500,000	10,000,000	25,000,000
Component 3	25,000,000	30,862,677	5,862,678	61,725,355
Subcomponent 3(i)	25,000,000	25,000,000		50,000,000
Subcomponent 3(ii)	0	5,827,677	5,827,678	11,664,000
Audit of grant funds	0	35,000	35,000	70,000
Undisbursed balance	**111,725,355**	**55,862,678**	**0**	**0**

6.7 **Internal control and internal auditing:** The MSPS and ADRES Offices of Internal Oversight perform the following roles: (i) provide technical assistance and advise committees; (ii) evaluate, monitor, and assess risk; (iii) foster a culture of oversight; and (iv) liaise with the CGR and National Archives. Internal control is provided for under Law 87/1993.

6.8 **External control and reporting:** The CGR conducts annual external audits in a selective manner following the close of the fiscal year, which is done independently at the MSPS and ADRES. Additionally, because the MSPS has a quality certification for its processes, every year it must hire an external firm to conduct audits of compliance with the procedures that have quality certifications under ISO-9001.

6.9 The Bank will accept ADRES financial statements audited by the CGR, provided technical assistance from a consulting firm is available during the audit process and audit documents are subsequently reviewed by a consultant to ensure the quality of the auditing process, since the CGR is not eligible to audit Bank projects. Loan proceeds from CO-L1154 will fund these consulting services for 2020, and the Bank will finance them for 2021 and 2022. For the 2020 audit, agreements have been made with the CGR to include the project in a pilot audit process under execution of the program financed through operation CO-L1154 and to implement an action plan resulting from a 2018 assessment of the CGR using the Supreme Audit Institutions Performance Measurement Framework (SAI-PMF) methodology. If the CGR does not audit ADRES financial statements for 2021 and 2022, the financial statements must be audited by a Bank-acceptable independent audit firm to be hired in accordance with Bank policies and procedures and financed with loan proceeds.

6.10 The consolidated financial statements for Grant Facility and PSG funds will be audited annually by a Bank-acceptable independent audit firm, and the audit will be financed with the grant funds (estimated budget: US$70,000). The auditing services will be engaged following procedures and terms of reference previously agreed upon with the Bank.

6.11 Audited financial statements for each instrument will be submitted to the Bank within 120 days of the closing of each MSPS fiscal year during the original disbursement period or any extensions thereto. The final audited financial statements for each instrument will be submitted within 120 days of the date of the last disbursement. Pursuant to the Bank's current Access to Information Policy, the project audited financial statements will be published on Bank systems.

6.12 **Supervision plan:** The Bank will conduct an annual *in situ* review that will involve verification of fiduciary agreements used to administer the program and, in particular, those related to monitoring resources execution through ADRES, in accordance with the requirements defined herein.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/20

Colombia. Loan ____/OC-CO to the Republic of Colombia
Program to Improve the Sustainability of the Health
System in Colombia with an Inclusive Approach

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Colombia, as borrower, for the purpose of granting it a financing to cooperate in the execution of the Program to Improve the Sustainability of the Health System in Colombia with an Inclusive Approach. Such financing will be for the amount of up to US$150,000,000 from the resources of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on ___ _____ 2020)

LEG/SGO/CAN/EZSHARE-1274791288-22392
CO-L1248

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/20

Colombia. Nonreimbursable Investment Financing ____/GR-CO to the Republic of Colombia. Program to Improve the Sustainability of the Health System in Colombia with an Inclusive Approach

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, as Administrator of the IDB Grant Facility (hereinafter referred to as the "Account"), to enter into such contract or contracts as may be necessary with the Republic of Colombia, as beneficiary, for the purpose of granting it a nonreimbursable investment financing to cooperate in the execution of the Program to Improve the Sustainability of the Health System in Colombia with an Inclusive Approach. Such nonreimbursable investment financing will be for an amount of up to US$9,625,000, which form part of the Account, and will be subject to the Terms and Financial Conditions and the Special Contractual Conditions in the Project Summary of the Nonreimbursable Investment Financing Proposal.

(Adopted on ___ _____ 2020)

LEG/SGO/CAN/EZSHARE-1274791288-22393
CO-L1248

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-__/20

Colombia. Nonreimbursable Investment Financing GRT/__-____-CO
Program to Improve the Sustainability of the Health System
in Colombia with an Inclusive Approach

The Board of Executive Directors

RESOLVES:

1. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such agreement or agreements as may be necessary with the Republic of Colombia, for the purpose of granting it a nonreimbursable investment financing for a sum of up to €2,000,000 chargeable to the resources granted by the Government of Germany through the Federal Ministry of Economic Cooperation and Development (BMZ), pursuant to the agreement or agreements specified in paragraph 2 below, and to adopt any other measures as may be pertinent for the execution of the project proposal contained in document PR-____.

2. That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such agreement or agreements with the Government of Germany as may be necessary to receive and administer resources for the purposes described in the project proposal specified in paragraph 1 above, and to adopt any other measures as may be pertinent for the execution of said agreement or agreements.

3. That the authorization granted in paragraph 1 above will be effective once the Bank and the Government of Germany have entered into the corresponding agreement or agreements to which reference is made in paragraph 2.

(Adopted on ___ _____ 2020)

LEG/SGO/CAN/EZSHARE-1274791288-22975
CO-G1019

PROGRAM TO IMPROVE SUSTAINABILITY OF THE HEALTH SYSTEM IN COLOMBIA WITH AN INCLUSIVE APPROACH

CO-G1019

CERTIFICACIÓN

I hereby certify that this operation will be authorized for financing through a Project Specific Grant (PSG) administration agreement or agreements for an amount of up to **EUR2,000,000** (**US$2,210,900** equivalent**)** to finance the activities described and budgeted in this document.

Donor's commitment does not have validity until the PSG administration agreement between the IDB and the donor is agreed upon and signed for this operation. Therefore, this certification will remain conditional until the corresponding PSG administration agreement or agreements are signed and effective.

Certified by: (Original signed) 2/27/20

Sonia M. Rivera
Chief
Grants and Co-Financing Management Unit
ORP/GCM

Date