DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

COLOMBIA

EXPANSION OF THE PROGRAM FOR THE REORGANIZATION, REDESIGN AND MODERNIZATION OF HEALTH SERVICE NETWORKS

(CO-L1017)

LOAN PROPOSAL

This document was prepared by the project team consisting of Antonio Giuffrida, Project Team Leader (RE3/SO3); Loreto Biehl (COF/CCO); Baudouin Duquesne (RE3/SO3); Ethel Muhlstein (RE3/SO3); Juan Carlos Perez-Segnini (LEG/OPR); and Leslie Stone (RE3/SO3).

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ABBREVIATIONS

ARS	Subsidized-regime administrators
CESI	Committee on Environment and Social Impact
CNSSS	National Health Care Social Security Council
CONPES	National Economic and Social Policy Council
DAF	Office of Fiscal Support
DGCPTN	Office of Public Credit and the National Treasury
DNP	National Planning Department
DTSs	Local health departments
ENDS	National Population and Health Survey
EPS	Health promotion institution
FOSYGA	Fondo de Solidaridad y Garantía [Solidarity and Guarantee Fund]
FTD	Fixed-term deposits
GDP	Gross domestic product
IMF	International Monetary Fund
IPS	Institutional health care providers
IRR	Internal rate of return
MHCP	Ministry of Finance
MPS	Ministry of Social Protection
MRPD	Mission to Reduce Poverty and Inequality in Colombia
OC	Ordinary Capital
PAB	Basic Health Care Plan
PCU	Project coordination unit
PNPSS	National Health Care Policy
POS	Compulsory Health Plan
PTI	Poverty-targeted investment
SEQ	Social equity enhancing project
SGP	General revenue-sharing system
SGSSS	General Social Security System for Health Care
SISBEN	Beneficiary Selection System
SOGC	Mandatory Quality Assurance System
WHO	World Health Organization

PROJECT SUMMARY

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EXPANSION OF THE PROGRAM FOR THE REORGANIZATION, REDESIGN AND MODERNIZATION OF HEALTH SERVICE NETWORKS
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<table>
<tr><th colspan="6">Financial Terms and Conditions[1]</th></tr>
<tr><td colspan="3">Borrower: Republic of Colombia</td><td>Amortization period:</td><td colspan="2">25 years</td></tr>
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<tr><td>Source</td><td>Amount</td><td>%</td><td>Interest rate:</td><td colspan="2">Adjustable</td></tr>
<tr><td>IDB (Ordinary Capital)</td><td>US$50 million</td><td>100%</td><td>Inspection and supervision fee:</td><td colspan="2">0%</td></tr>
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<tr><td>Other/Cofinancing</td><td></td><td></td><td rowspan="2">Currency:</td><td colspan="2" rowspan="2">US dollars from the Single Currency Facility of the Bank’s Ordinary Capital</td></tr>
<tr><td>Total</td><td>US$50 million</td><td>100%</td></tr>
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Project at a glance

Project objective:

The project's long-term objective (goal) is to help improve the health of the Colombian people. The program seeks to enhance the efficiency, quality, and financial sustainability of public-sector health care provider networks. The program will have two phases. The first will finance three components: (i) reorganization of networks of public-sector institutional health care providers; (ii) implementation of priority projects in accordance with the national health care policy; and (iii) monitoring and evaluation.

Special contractual conditions: None.

Exceptions to Bank policies: A revolving fund of up to 15% of the loan amount is requested pursuant to OA-345 (see paragraph 3.20).

Project consistent with country strategy: Yes [X] No [ ]

Project qualifies as: SEQ [X] PTI [X] Sector [ ] Geographic [ ] Headcount [ ]

Verified by CESI on: 7 April 2006.

Environmental and social review: See paragraphs 4.6 to 4.9.

Procurement: See paragraphs 3.17 to 3.19 and Annex II (Procurement Plan).

[1] The interest rate, credit fee, and inspection and supervision fee mentioned in this document are established pursuant to document FN-568-3 Rev. and may be changed by the Board of Executive Directors, taking into account the available background information, as well as the respective Finance Department recommendations. In no case will the credit fee exceed 0.75%, or the inspection and supervision fee exceed 1% of the loan amount.[*]

[*] With regard to the inspection and supervision fee, in no case will the charge exceed, in a given six-month period, the amount that would result from applying 1% to the loan amount divided by the number of six-month periods included in the original disbursement period.

I. FRAME OF REFERENCE

A. Socioeconomic framework

1.1 The Colombian economy has slowed significantly since the second half of the 1990s. In the first quarter of 1999, after a brief growth bubble in 1998, Colombia was plunged into its deepest crisis in 70 years. Throughout 1999 and 2000 the country had to contend simultaneously with GDP declines, financial system upheaval and serious problems with mortgage borrowers, a fiscal crunch in the subnational governments, contingent liabilities for pensions and concessional infrastructure guarantees, and a widening central government deficit. These problems unfolded against a backdrop of limited external financing and escalated activity by armed groups. Upon taking office in 2002, the current administration tackled the country's macroeconomic and fiscal crisis with a structural reform plan designed to rein in the deficit and stimulate the economy. It has also adopted an alternate strategy in relation to violence.

1.2 These policies have bolstered Colombia's economy, as evidenced by a considerable rise in productivity since 2003. This solid macroeconomic performance has helped Colombia meet all the targets of the stand-by arrangement with the International Monetary Fund (IMF). GDP grew by an estimated 5.1% in 2005. Inflation has remained stable, with consumer prices rising 5.1%. The liquidity of the local financial market has allowed the government to improve its debt rating despite high levels, by changing the denomination and lengthening the maturities of its debt. The country posted a nonfinancial public-sector deficit of 0.9% of GDP (under the 2.5% target set with the IMF) as a result of Ecopetrol's operational surplus (3.5% of GDP) and the sustained surplus of subnational governments (1.1% of GDP). Lastly, the standard country risk indicator (EMBI+) fell from 260 basis points in December 2004 to 162 basis points in February 2006.

1.3 The Colombian government and an IMF mission reached agreement recently—with approval by the Executive Board of the IMF expected in May 2006—on the second review of the IMF program, approved in April 2005. In view of the country's macroeconomic and fiscal gains, the government agreed to: (i) maintain a fiscal policy aimed at cutting gross public debt to 40% of GDP by 2010; (ii) strive to maintain a current account deficit of 1.6% of GDP in 2006, below the original target of 2%; (iii) seek to strengthen fiscal policy even further in the proposed budget to be sent to Congress in July 2007; and (iv) step up structural reforms in 2006, especially in tax policy, the general revenue-sharing system (SGP), and the financial sector.

1.4 Except for the worst years of the economic crisis, Colombia has made steady progress in social development in recent years. According to the United Nations Development Programme, Colombia is now at an intermediate level of human development, up to 69th out of 177 countries. This progress includes greater access to education, with over 80% attendance at mandatory preschool, near-universal

access to primary education, and a secondary school enrollment ratio of 78%. Also, life expectancy at birth is now approximately 72.4 years. Social spending, meanwhile, has risen sharply from 5.4% of GDP in 1995 to 8.8% in 2004.

1.5 Despite this social progress, poverty remains a critical problem. While the poverty rate has fallen from 57.5% in 1999 to 52.6% in 2004, it is still quite high and has not returned to its pre-crisis level of 50.9% in 1996.[1] This seeming contradiction between major improvements in social development and modest poverty reduction can be attributed to 15 years of slow growth in per capita GDP (1% per year on average)[2] and to a rise in unemployment.[3]

B. Health care reform in Colombia

1. Overview

1.6 This operation will support expansion of the program for the reorganization, redesign, and modernization of health service networks (1525/OC-CO), approved by the Bank in January 2004, which is an integral part of an ambitious effort to reform the Colombian health sector. This section provides an overview of these reforms. Subsequent sections will: (i) provide a more detailed description of the major components of the health care system; (ii) outline gains of the reforms; and (iii) review current problems. Based on this background information, section C will focus on the country strategy for resolving current problems and making progress in program 1525/OC-CO, developed as an integral part of the ambitious effort to reform the health sector in Colombia.

1.7 Law 100 of 1993 marked the beginning of the health sector reforms by setting the basic legal framework. The sector had a three-tiered institutional structure: (i) the wholly private system, providing higher-quality health care to the small percentage of the population with the highest income; (ii) the social security system, serving employees in the formal sector (some 20% of the population) through the Social Security Institute and other entities; and (iii) the publicly funded system, providing services (usually low-quality) through institutional health care providers (IPSs) of the Ministry of Health to lower-income earners and/or those not covered by social

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[1] Estimates by the Mission to Reduce Poverty and Inequality in Colombia.

[2] The armed conflict is estimated to have cost two percentage points in GDP growth since 1992 (See: UNDP "Human Development Report", 2005).

[3] According to Banco de la República's economic information system, the national unemployment rate in January 2001 was 17%. While this figure has fallen in recent years, unemployment remains a serious issue in Colombia (13.4% as of January 2006).

security.[4] The sector was marked by low coverage rates, poor quality, inefficiency, and inequity.

1.8 In light of these conditions, three main objectives were set for the reforms: (i) to achieve health insurance coverage for the entire population; (ii) to use resources more efficiently; and (iii) to raise the quality of care. A three-pronged strategy was devised to meet these objectives: (i) mandatory, universal health insurance for the entire population; (ii) decentralization of health care services; and (iii) transformation of the financing and management structure of health care provider networks.

1.9 The reform process would be driven by managed competition based on two competitive markets: health insurance and health care services. In the first of these two markets, members of the General Social Security System for Health Care (SGSSS) have the right to choose their insurer, forcing insurers to compete for members based on service quality. Insurers receive a capitation grant, set and paid by the government, in exchange for guaranteed provision of a compulsory health service plan (POS) to its members. In the second market, insurers purchase health services on behalf of their members, selecting and negotiating the best value among public and private health care providers.[5]

1.10 Management of the SGSSS, including its oversight and control, is the responsibility of the State through the Ministry of Social Protection (MPS), the National Superintendent of Health, the National Social Security Council for Health Care (with broad participation of all sector stakeholders) and public-sector authorities at the departmental and municipal levels.

1.11 The reform process highlighted the need for a comprehensive system for quality assurance in health care based on the following principles: (i) determination of the essential requirements and minimum structural conditions for a health care provider to operate, accreditation for institutional enhancement, and audits for the ongoing monitoring of quality of health care services; and (ii) implementation of an information system on the quality of health care services, so that the incentives inherent in a system based on managed competition are leveraged to yield the desired improvements in health care.

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[4] The Ministry of Social Protection (MPS) was established in February 2003, merging the former Ministry of Health and Ministry of Labor.

[5] The Constitutional Court has repeatedly held (in Ruling C-480/97 and elsewhere) that if a member's life may be endangered by denial of a service excluded or not covered by the POS, the insurer must treat the member and may then request reimbursement from the Solidarity and Guarantee Fund (FOSyGA), or otherwise notify the patient so that he or she may seek assistance from public and private institutions under contract to the State, which must then treat the patient to the extent they are able.

2. Health insurance and health care financing

1.12 Colombia's health insurance system was created with the establishment of the General Social Security System for Health Care (SGSSS)under Law 100 of 1993. The SGSSS is based on the requirement that all people be insured under one of two plans: the *contributory regime* or the *subsidized regime* funded through the Solidarity and Guarantee Fund (FOSyGA).[6]

1.13 The **contributory regime** is designed to cover wage-earners earning the minimum wage or more, as well as self-employed workers earning more than 1.5 times the minimum wage. This system is funded entirely through employee and employer contributions (4% and 8% of income, respectively). Employees and their families are insured through entities known as health promotion institutions (EPSs).

1.14 The **subsidized regime** covers those unable to afford the contributory regime.[7] The subsidized regime draws funds from various sources, such as FOSyGA, transfers from the national government to subnational entities through the general revenue-sharing system (SGP),[8] and any internally generated funds that departments or municipios can contribute. Subsidized-regime administrators (ARSs) were created to administer the subsidies.[9]

1.15 All citizens are also guaranteed a **Basic Health Care Plan** (PAB), run by the local health administrations (DTSs) and funded by transfers from the SGP and own resources. The PAB is a package of health promotion activities, epidemiological vigilance, environmental sanitation, and disease prevention campaigns; there is also a **Plan for Catastrophic Events and Traffic Accidents** and **emergency care** throughout the country.

1.16 Until the goal of universal health coverage is met, the uninsured poor receive health care services mainly through the public-sector health care provider networks.

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[6] Sources of revenue for the FOSyGA include: (i) 1% of the solidarity contribution from the contributory regime; (ii) 5% to 10% of the funds from the family benefit funds known as *cajas de compensación familiar*; (iii) the State contribution (at least 25% of the revenue collected in (i)); (iv) returns on investments of FOSyGA funds; (v) a percentage of the operating revenues from the Cusiana and Cupiagua oil fields. and (vi) a tax on guns and ammunition, etc. Funds in the FOSyGA are allocated to four subaccounts: the contributory regime, the subsidized regime, care for catastrophic illnesses and traffic accidents, and promotion and prevention programs.

[7] The subsidized regime is open to the poorest groups, those in levels 1 and 2 of the beneficiary selection system (SISBEN). SISBEN is a family socioeconomic classification tool used by municipios.

[8] The SGP represents the share of current income (revenues from the value-added tax, income tax, and levies on foreign trade) that the national government transfers to departments and municipios to finance health care, education, and other services.

[9] The POS of the subsidized regime is defined in Article 156 of Law 100/93 as a comprehensive health care plan covering preventive care, medical and surgical care, and essential medications.

Article 49 of Law 715 of 2001 describes the SGP resources allocated to funding health care services for the uninsured poor (supply subsidies) and the methodology for allocating funds to subnational entities.[10] Law 100 of 1993 required subnational entities to replace traditional payment methods (determined by past budgets) with payment methods determined by services actually provided, as did Law 812 of 2003.

1.17 These people's access to health care is hindered by a lack of information on how to access care and insufficient funding to provide it.[11] This is in addition to the vague content of the benefit plans; in fact, there is no benefit plan for the uninsured. Meanwhile, the results of the First National Survey on Consumer-Perceived Quality in Health Care, administered in 2000, show that the uninsured poor received more timely care in both general and specialized medicine than subsidized-regime members. The opposite situation prevails in promotion and prevention services, where subsidized-regime members receive better care than nonmembers.[12]

3. Decentralization in health care services

1.18 Law 715 of 2001 empowered the departments to fund and ensure the provision of secondary and tertiary health care, gave certified municipios the same responsibilities for primary care.[13] Also, Law 100 of 1993 made subnational entities (municipios and departments) responsible for the public health activities included in the PAB[14] and allocating the subsidies to health insurance.

1.19 As a result of the decentralization process, the health authorities of the subnational entity or the regional health department (DTS) is responsible for organizing health care services in their jurisdiction into provider networks. The networks were based of such factors as: (i) demand for services (area population, demographic and epidemiological profile, type of membership in the SGSSS, consumer preferences); (ii) supply of services (identification, description, and evaluation of public and private providers, and available resources); and (iii) important logistical and

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[10] SGP resources are allocated to uninsured poor people requiring care throughout the country. The resulting per capita amount is multiplied by the number of poor people requiring care in each municipio and district, and is adjusted for population dispersion and by an adjustment factor that weights services not included in the POS.

[11] While each member of the subsidized regime has US$192,344 a year, per capita funding for the uninsured poor is around US$60,000 per year.

[12] Office of the Ombudsman. "First National Survey on Consumer-Perceived Quality in Health Care," Bogota, 2000.

[13] In 2006, 491 municipios administer primary health care services. The department evaluates these municipios annually, to determine whether they are qualified to do so.

[14] Article 46 of Law 715 of 2001 made subnational entities responsible for promotion and prevention activities under the POS for subsidized-regime members.

operational issues for the system of referrals and counter-referrals (communication, transportation, and access systems).

1.20 Meanwhile, the financing and management mechanisms for public-sector IPSs have been transformed. They became "state social enterprises" (Law 100 of 1993)—decentralized government agencies with their own separate legal status, capital, and administrative autonomy that have to support themselves by charging for services. The transformation has created a major challenge for public-sector providers, which now had to operate like private companies—marketing, hiring, and billing insurance companies and subnational entities. From an operational point of view, providers have had to implement or improve management, administrative, and financial processes, many of which had not existed prior to the reforms.

4. Major achievements of health care reform in Colombia

1.21 The greatest achievement of the reforms has been increased coverage (the percentage of the population insured rose from 28% to 69% between 1992 and 2005).[15] The most significant gains were in terms of equity: coverage of the poorest 20% of the population rose from 4.2% to 57.6%.

Table 1: Health insurance coverage, 1992-2005

	1992	1997	2000	2005
Total population	32,113,615	40,064,093	43,035,394	45,325,260
Subsidized-regime members	-	4,800,916	9,510,560	18,578,760
Contributory-regime members	8,964,816	14,969,278	13,063,046	15,421,930
Insurance coverage	28%	49%	52%	69%
Coverage of Q1 (poorest)	4%	43%	35%	58%
Coverage of Q5 (wealthiest)	55%	79%	75%	86%

1.22 The 11.3 million Colombians who are not yet members of the SGSSS include 6 million poor (SISBEN levels 1 and 2) who should become members of the subsidized regime, 2.4 million who can afford partial payments (SISBEN level 3, the so-called "sandwich population"), and some 3 million who are able to pay but are not members of the contributory regime (SISBEN levels 4 and 5).

1.23 This expansion has been supported by a considerable increase in public spending on health care. Prior to Law 100 of 1993, Colombia spent 3% to 5% of GDP on health

[15] Data from the National Population and Health Survey (ENDS), 2005.

care.[16] Today Colombia spends over 9% of GDP on on health care—5.5% from public spending and the remainder from private and parafiscal contributions.

1.24 As proof of the success of Colombia's health care reforms, in 2000 the World Health Organization (WHO) ranked Colombia as the country with the most equitable health care financing system of its 191 member countries. The WHO also ranked Colombia first in the Americas (22nd in the world) for overall performance of the health sector.[17]

5. Current problems and challenges

1.25 The reforms increased the pressure exerted by the financial needs of public-sector IPSs. Initially, this was seen in the use of additional resources transferred by the national government to subnational entities. From 1994 to 1997, the number of health sector employees grew 21%, while the number of administrative support staff rose 73%, a much higher rate than that of health care providers.[18] In addition, collective bargaining agreements were so favorable to workers that some were making as much as an alarming 27.9 times the minimum wage. Funding was also provided to expand health services at the municipal and departmental levels by creating or expanding institutions or services without regard to demand or installed capacity in both the public and private sectors.

1.26 Without a shift in health care financing from supply subsidies to demand subsidies, this uncontrolled increase in the number of employees, compensation levels, and capacity of physical facilities would degrade the financial condition of public-sector IPSs. Secondary- and tertiary-care IPSs began posting deficits in 1995 and 1996, respectively. Deficits at primary-care IPSs began growing in 1997, and by 2000 had exceeded those of secondary- and tertiary-care IPSs (Figure 1).[19]

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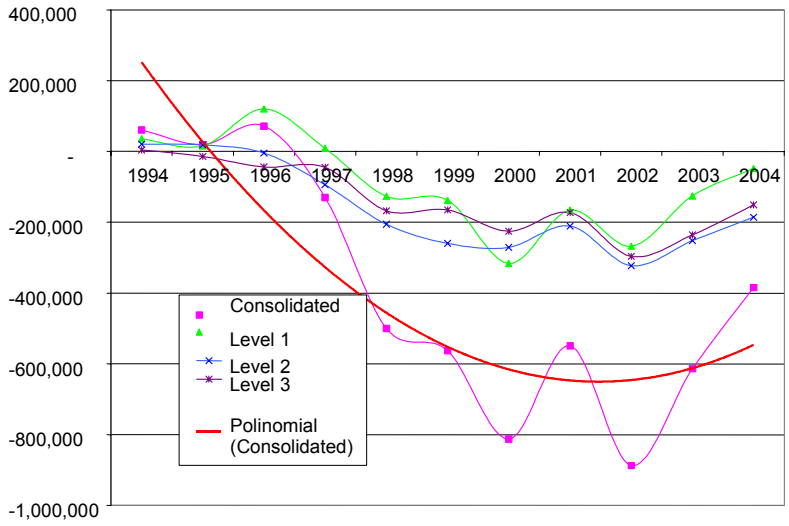
[16] These resources came mostly from revenues assigned to the departments (proceeds from taxes on liquor, beer, lotteries, gambling, registration fees) and intergovernmental transfers.

[17] WHO. "The World Health Report 2000. Health Systems: Improving Performance," Geneva, 2000.

[18] Census on Human Resources and Wage Dynamics, 1994-1998.

[19] IPSs can be divided into three levels of care, based on their utilization of human and technological resources: (i) primary care, for local hospitals and health facilities providing basic health care; (ii) secondary care, including local or regional hospitals providing specialized care; and (iii) tertiary care, covering major hospitals with advanced medical technology.

Figure 1: Deficits in public-sector IPSs, 1994-2004 (in millions of Colombian pesos)
Source: DNP



1.27 The crisis in public-sector IPSs has multiple causes, including: (i) a bloated structure for administering and providing health care, disproportionate to actual demand in terms of physical and human resources; (ii) high costs due to nonproductive positions and high wage and benefit burdens; and (iii) a lack of information for decision-making.

1.28 There are also **internal factors related to management of health care providers**: (i) ineffective implementation of management processes; (ii) ineffective management of sales-related contracting processes and low billing levels; and (iii) ineffective implementation of information systems. Resources were shifted from supply to demand more quickly than public-sector IPSs could make the institutional adjustments needed to support themselves by billing for services, which led to a decline in resources.

1.29 **External factors** have also posed obstacles to the self-sustainability of public service providers: (i) severance payments, required under labor legislation, that exceed the financial capacity of public-sector IPSs; (ii) the high cost of human resources in the public sector;[20] (iii) the low level of development and limited

[20] Especially administrative staff (7% higher) and nurses (20% higher). See: Ministry of Health. "Los recursos humanos de la salud en Colombia. Balance, competencias, y prospectiva [Human resources in health care in Colombia: Overview, qualifications, and outlook]" Bogota, 2001.

capacity of DTSs; and (iv) lack of development of the SGSSS information system, making it difficult to control evasion and avoidance.

1.30 The crisis in public-sector IPSs is financially and socially unsustainable. Accumulating liabilities have led to suspension of health services due to a lack of essential inputs and supplies. This is especially serious because of the importance of public-sector IPSs for the health care system and their role in providing health care to the poor unserved by the SGSSS or the subsidized regime, since they provide coverage in remote areas where there are no other providers. The growing liabilities of public-sector IPSs make them less financially viable and have become a major factor in the deficit accumulated by the subnational nonfinancial public sector.

1.31 Lastly, the rigid cost structure of public-sector IPSs—especially in terms of labor costs—prevents them from adjusting to the health financing system established by Law 100, which is based on prospective budgets. It has also limited the ability to convert supply subsidies to coverage under the subsidized regime (demand subsidies).

C. The country's sector strategy

1.32 In view of current conditions in the health sector, the importance of public hospitals in the SGSSS, and their impact on national and local government finances, the government has been gradually working to restructure public health care networks since 1999, when the first pilot project began.[21] Meanwhile, Law 812 of 2003, in creating the 2003-2006 National Development Plan, called for improvements in "access to and provision of health care services in the system through the restructuring and funding of hospitals, regulating the entry of IPSs to the SGSSS, promotion of accreditation mechanisms to raise quality, and the creation of health care networks."

1.33 The Bank's approval of the program for the reorganization, redesign, and modernization of health service networks (1525/OC-CO) in January 2004[22] marked the start of a new stage in which IPS institutional restructuring was tied in to the operational design of the health service networks. As part of the restructuring process, the national government and subnational entities enter into 10-year agreements for internal loans that can be forgiven, subject to annual demonstration that targets and commitments in performance agreements are met, as measured by

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[21] The pilot project was financed with US$30 million redirected from two Bank loans (716/OC-CO and 910/OC-CO), and US$45 million equivalent from the Government of Colombia.

[22] Program 1525/OC-CO was for US$90 million, broken down as US$72 million in loan proceeds and US$18 million from the local contribution. A total of 70.1% of the loan proceeds was used to cofinance the payment of outstanding wages, severance, and benefits for staff members whose jobs were cut. The remaining 29.9% was used for other activities: technical assistance for the IPSs and DTSs, monitoring and evaluation, and program management.

indicators included in the matrix of eligibility for loan forgiveness. The most important stages of the program cycle are as follows:

a. **Redesign**, including: (i) development of proposals by subnational entities to reorganize the IPSs into a service network (see paragraph 1.19),[23] (ii) proposal viability assessment by the MPS and the National Planning Department (DNP); and (iii) signature of performance and loan agreements with subnational entities and IPSs.

b. **Reorganization**of IPSs, including: (i) adjustment of the IPSs' service portfolio; (ii) staff reduction; (iii) payment of outstanding wages, severance, and benefits with funding from the national government; and (iv) payment of priority liabilities.

c. **Modernization** of IPS and DTS management through actions to ensure that gains from organizational fine tuning at the IPSs are sustainable, and to enhance efficiency, quality, and timeliness in service delivery. These activities are related to efforts to improve management processes in hospitals and enhance the quantity and quality of services.

1.34 Interventions have been carried out at 179 public-sector IPSs since 1999, 88 under program 1525/OC-CO (71 in 2004 and 17 in 2005). Program 1525/OC-CO is executing rapidly with great success. Thus far, US$67.1 million (93%) has been committed—allocated mainly to fund the operational redesign and reorganization of public-sector IPSs—and US$53.7 million (75%) has been disbursed. The uncommitted balance of US$4.9 million (7%) is for technical assistance to modernize public-sector IPSs, as well as program monitoring, evaluation, and administration. Program completion is slated for end-2007.[24]

1.35 Given the nature of the program cycle, outcomes can only be observed in the medium term; the impact of reorganization can currently be studied in 71 IPSs included in agreements between 1999 and 2002 (see Table 2). A midterm review as of 30 October 2005 was also done on the 71 IPSs intervened in 2004 under program 1525/OC-CO. It assessed progress in terms of staff reductions and output targets.[25]

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[23] Technical-cooperation operation ATN/JO-7650-CO supported the development of tools and models for the reorganization of health service networks.

[24] Significantly, the spread between the exchange rate at which the operation was dimensioned (2,900 Colombian pesos to the U.S. dollar in January 2003) and the current exchange rate (2,270 to the dollar in January 2006) has shrunk the local-currency resources available for program needs, leaving an unfinanced balance of approximately 32.4 billion Colombian pesos.

[25] See: MPS. "Informe de avance de los convenios subscritos en la vigencia 2004 con corte a octubre 2005 [Progress report on agreements signed from 2004 to October 2005]," available in the RE3 project technical files.

1.36 A key target of the reorganization process—in addition to the resizing of IPSs—is for IPSs to bring their service portfolio and **output level** into line with the needs of departmental subnetworks. If this target is met, it would mean that the IPSs are successfully compensating for the staff reductions by becoming more productive and efficient. Table 2 shows that the average increase in output of outpatient and surgical services was significant, and the MPS progress report shows that departments on average met or exceeded output targets.

Table 2. Changes in key indicators at intervened IPSs

	Indicator	Year 0	Year 2*	Change (%)
1.	**Service output**			
	Outpatient services (number of visits)[1]	2,879,560	3,583,892	24.5
	Surgical services (number of surgeries and infant deliveries)[2]	281,103	335,512	19.4
	Total equivalent output (number of units)[3]	4,444,136	5,055,679	13.8
	% Occupational	74.5	80.4	7.9
	Bed turnover	59.5	65.1	9.4
2.	**Cost structure**			
	Number of staff	20,023	12,594	-37.1
	Total payroll expenses (in millions of 2004 U.S. dollars)[4]	570,551	362,517	-36.5
	Total staff costs (in millions of 2004 U.S. dollars)[5]	634,746	490,304	-22.8
	% Staff costs / total expenses	69.3	61.7	-11.0
	Total expenses (in millions of 2004 U.S. dollars)[6]	915,451	794,472	-13.2
	Expense per unit of output (in 2004 U.S. dollars)[7]	205,991	157,145	-23.7
3.	**Deficit/surplus based on revenue intake**			
	Difference between revenue intake and expenses (in millions of 2004 U.S. dollars)[8]	-321,015	-48,938	-84.8

* Year 0 is the year the intervention process began. Year 2 is the fiscal year equivalent to two years later.

[1] Outpatient services: the total number of elective and emergency visits by both general physicians and specialists for all IPSs each year.

[2] Surgical services: the total number of elective and emergency surgeries, infant deliveries, and C-sections performed for all IPSs each year.

[3] Equivalent total output: the sum of all outputs generated by each IPS each year in day-stay equivalent terms, including outpatient, surgical, and hospital services.

[4] Total payroll expenses: total expenses committed by all IPSs, including wages and payroll-related services and contributions.

[5] Total staff costs: total expenses committed for all IPSs each year, including total payroll expenses (4) plus indirect labor intermediation services.

[6] Total expenses: total expenses committed by all IPSs each year.

[7] Expenses per unit of output: total expenses committed to generate each equivalent unit of output by all IPSs each year (6/3).

[8] Deficit/surplus: difference between revenue intake and expenses committed by all IPSs each year.

Source: Ministry of Social Protection

1.37 **Staffing cutbacks** to reduce staff costs[26] and staff size at IPSs according to level of complexity, level of output, and demand involves retirements and payment of outstanding wages, severance, and benefits. Table 2 shows that the number of staff shrank by 37%, while total staff costs fell 22%. The MPS progress report shows that, as of late October 2005, on average, 71.68% of public-sector employees and 54.44% of government workers included in operational reorganization plans of the IPSs had left and been paid outstanding wages and severance.[27]

1.38 In 2005, after identifying the main problems in the health system—both existing and emerging—the MPS established a **National Health Care Policy (PNPSS)**.[28] The policy's objectives are: (i) to improve access to health care; (ii) to improve quality in health care; and (iii) to make health care services more efficient, and public-sector IPSs financially sustainable. The policy implementation plan maps out the following strategies:

a. The **access component** includes strategies to strengthen health service networks, improve decision-making capacity in providing low-complexity and emergency health care, and expand health insurance for the poor and vulnerable groups.

b. The **quality component** focuses on effectively implementing the mandatory quality assurance system (SOGC), fostering the development of human talent,[29] and reducing information asymmetries by making information available to users on the quality of services provided by EPSs, ARSs, and IPSs.

c. For the **efficiency component**, which is more focused on the public health care provider network, strategies are aimed at improving structural and operational conditions of such institutions.

D. The Bank's sector strategy

1.39 In terms of the key action areas of the ***Bank's country strategy with Colombia*** (document GN-2267-1), the operation will help principally to promote social development and ensure that society's most vulnerable are protected. First, the resizing of public hospitals will contribute to financially sustainable social services

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[26] Regular staff of IPSs under restructuring receive an average of 22 to 25 basic benefits a year.

[27] The average payment to staff laid off (severance and outstanding wages) has been 23.83 million Colombian pesos, equivalent to US$10,832.

[28] MPS. "Política Nacional de Prestación de Servicios de Salud," Bogota, November 2005. Available in the RE3 project technical files.

[29] The SOGC, as established under Decree 2309 of 2002 and its implementing regulations, has four components: the single qualification system, the health care quality improvement audit, the single accreditation system, and the information system for quality.

that meet the needs of the population more effectively and use resources more efficiently. Protecting investment in human capital by improving health conditions will boost the potential for economic growth, thereby helping to lay the foundation for revitalizing and stimulating the economy. The process of reorganization, redesign, and modernization of public-sector IPSs will also promote efficiency in government and enhance governance by supporting the process of government reform.

1.40 This operation will contribute principally to the first objective of the ***Bank's strategy on social development*** (document GN-2241-1) by expanding health insurance coverage and promoting the efficient use of public resources allocated to health care.

E. Program strategy

1.41 In accordance with Bank policies (document GN-2085-2), the proposed operation will be a **multiphase program**, so as to provide systematic, longer-term support for the public health-care networks program, which due to its scope and complexity will require more than one project cycle to be completed. This operation will also help provide ongoing support for implementation of the PNPSS, and particularly the strategic components of efficiency and quality (see paragraph 1.38).

1.42 While the consolidated deficit of public-sector IPSs has shrunk (see Figure 1) as a result of reorganization efforts, financially unsustainable institutions remain that require intervention. In addition, implementation of the PNPSS needs to be supported (see paragraph 1.38) through both financial resources and technical assistance. With the current administration set to leave office in August 2006, this first phase of the operation is expected to finance performance agreements between the national government and subnational entities[30] that were signed in 2006, covering the reorganization of some 40 IPSs[31] and modernization of the operations of 10 DTSs. Phase I is designed as an extension of program 1525/OC-CO, and will continue to support the reorganization of health service networks.[32] Phase II will expand the program horizontally by supporting the operational reorganization and modernization of some 58 IPSs. The second phase will also vertically extend actions to support the PNPSS, based on the findings of studies and analyses done in phase I.

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[30] See paragraphs 3.6 to 3.8 for a description of the performance agreements used in the program.

[31] The total number of IPSs to receive interventions using program resources may vary, depending on the level of care they provide and the reorganization activities required.

[32] Program 1525/OC-CO is expected to be completed by May 2007. Thus, the proposed operation would be carried out simultaneously with 1525/OC-CO.

F. Lessons learned and relationship with other Bank operations

1.43 Bank-financed investment projects—the health care improvement program (716/OC-CO), the program to support health sector reform (910/OC-CO), and the program for the reorganization, redesign and modernization of health service networks (1525/OC-CO), and the policy-based loan for the health care and social security reform program (1480/OC-CO)[33]—have played an important role in adjusting the tools and policies to implement sector reforms. This program is the direct outcome of the experience gained through these loans.[34] These loans, particularly 1525/OC-CO, have helped identify the need to: (i) institute a national policy supporting the formation of hospital networks; (ii) increase technical support for hospital management at the subnational level; and (iii) conduct an in-depth analysis of labor issues such as health-care labor cooperatives and job retraining for staff laid off from hospitals.

1.44 The proposed operation will also be coordinated with other Bank operations now in preparation. The FINDETER program (CO-L1012) will utilize second-tier banking to meet the need for comprehensive improvements in subnational entities, including construction, improved health care equipment, and better structures. The social reform and equity program (CO-L1014) deserves special mention, in that it sets milestones for implementation of the SOGC in the health sector, reinforcing the activities to be partially financed by this program. Lastly, the technical-cooperation operation to support implementation of the mandatory health care quality assurance system (CO-T1029) will complement this program.

G. Coordination with other donors

1.45 The effort to support Colombia in the implementation of reforms is being coordinated among multilateral agencies and the government. In the health sector, the IDB and the World Bank are working together to protect spending to finance expansion of the subsidized regime. The World Bank plans to include indicators on the operational reorganization of public-hospital networks in the third social-sector programmatic operation.

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[33] This program included conditions in its policy matrix to support the hospital resizing process. Specifically, evidence of signed agreements and a plan to restructure public hospitals had to be provided for the first tranche release, and evidence that the agreements and restructuring plan were being performed had to be provided for the second tranche release.

[34] Another Bank operation currently being executed in the health sector is the program to support the expanded program on immunization (1624/OC-CO), approved in May 2005. A systematic description of Bank support for the health sector in Colombia is available for consultation in the RE3 project technical files.

II. THE PROGRAM

A. Objectives

2.1 The project's long-term objective (goal) is to help improve the health of the Colombian people. The program seeks to enhance the efficiency, quality, and financial sustainability of public-sector health service networks. To meet this objective, the program will be structured in two phases.

2.2 This multiphase operation will be for a total amount of US$194 million, to be executed in two phases over approximately six years. Bank financing would be US$50 million for the first phase, and US$144 million for the second phase.[35] The triggers for the second phase are:

a. Use of resources from the first phase. The specific targets are: (i) 75% committed, and (ii) 50% disbursed.

b. Progress report on operation 1525/OC-CO, which will report on outcomes for 71 institutional health care providers (IPSs) covered in the agreements signed in 2004. The specific targets will be: (i) 15% average reduction in spending on hospital staff; (ii) 90% of the IPSs receiving interventions are financially stable; (iii) 90% of the output target for hospital and outpatient services is met for all IPSs combined;[36] and (iv) quality control system instituted in 80% of the IPSs receiving interventions.

c. Performance agreements entered into between the Ministry of Social Protection (MPS) and subnational entities as part of program phase I, in which the subnational entities agree to meet the following specific targets: (i) 15% to 20% average reduction in hospital spending; (ii) output targets for hospital and outpatient services remains constant; and (iii) targeted IPSs are financially stable.

d. Rollout of the quality information system, entailing annual quality reports and rankings of IPSs and health promotion institutions (EPSs).[37]

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[35] Subject to confirmation of budget headroom and technical analysis of phase I and operation 1525/OC-CO (see paragraph 2.2).

[36] The output level for hospital services may be adjusted due to the change in the service portfolio of network IPSs and the level of contracting by the subsidized-regime administrators (ARSs) with the public-sector network.

[37] Disseminating the rankings will make information on the quality of services provided by EPSs, ARSs, and IPSs available to the public, providing an incentive for these institutions to improve service delivery (see paragraph 2.2).

B. Program description

2.3 Phase I seeks to meet these objectives through the financing of four components.

1. Component 1. Reorganization of public-sector IPS networks (US$43.54 million)

2.4 This component will strengthen the reorganization, modernization, and redesign of health service networks, begun with proceeds from IDB loan 1525/OC-CO, as well as support PNPSS implementation at the local and institutional level. It will have the following subcomponents:

a. Operational reorganization of IPSs (US$34.15 million)

2.5 This subcomponent will finance, in accordance with Colombian law, the payment of outstanding wages, severance, and benefits for staff members whose positions are eliminated at IPSs in order to resize staff (number of staff members and required job descriptions) according to the service portfolio planned for each IPS in the redesigned network, so that IPSs can achieve financial sustainability through greater flexibility in their fixed costs. Reorganizing the IPSs may also entail merging several of them or, if resizing fails to make them financially viable or they have to be dissolved in order to reorganize the network.[38]

b. Network redesign and modernization (US$9.38 million)

2.6 This subcomponent will improve the quality of consumer-oriented health care and health services in terms of efficiency and financial sustainability, and be implemented on the basis of fulfillment of DTS and IPS accreditation standards. This subcomponent will finance technical assistance, training, management tools, computer equipment, software, and computer networks for:

a. DTSs to effectively perform their role as supervisors of health service networks, with an emphasis on: (i) coordination, management, and sustainability of the provider network; (ii) management of resources to provide services to poor people not covered by demand subsidies; (iii) implementation of the mandatory quality assurance system (SOGC); (iv) biomedical technology management at the subnational level; and (v) improved information technology for network operation and connectivity.

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[38] If redesigning the public-sector IPSs involves dissolving an IPS, the resources for this subcomponent will be allocated to pay outstanding wages, severance, and social benefits for staff of that IPS. In no case will program resources be used to finance accumulated debt stemming from the failure to pay wages, employee benefits, pensions, unemployment benefits, and payments owed to suppliers.

b. IPSs to achieve the desired quality and efficiency gains in service delivery, with an emphasis on: (i) financial management; (ii) management of human talent, including training and retraining for employees whose jobs are eliminated under the program (see paragraph 4.12); (iii) management of hospital inputs; (iv) biomedical technology management; (v) SOGC implementation;[39] and (vi) utilization of information technology for network operation and connectivity.

2. Component 2. Implementation of priority projects of the National Health Care Policy (PNPSS) (US$2.15 million)

2.7 This component will support implementation of priority projects of the PNPSS at the national level. It will finance technical assistance, training, and the purchase of equipment, software, and computer networks for such actions as: (i) implementation of the SOGC; (ii) changes to the regulatory framework for public-sector health care; (iii) development of projects to evaluate biomedical technology; (iv) implementation of a national pharmaceutical policy; (v) standardization of processes to manage human talent and health care inputs; (vi) strengthening of information technology for the operation and management of health service networks; and (vii) audits and evaluations of: (a) coverage and resources allocated by subnational entities to finance activities not included in the compulsory health service plan (POS) of the subsidized regime, (b) accounts receivable at public-sector IPSs vis-à-vis ARSs and local health administrations (DTSs), (c) management of resources allocated by the national government to pay employer contributions for employees of public-sector IPSs that lack the funds to do so, and (d) financing of public-sector IPSs where market conditions are such that they cannot be fully self-sustaining based on revenue from the sale of services.

3. Component 3. Monitoring and evaluation (US$1.13 million)

2.8 The purpose of this component is to monitor, oversee, and evaluate IPS and DTS management; program impact at the subnational and national levels; and progress in implementing the PNPSS. It will finance technical assistance for: (i) monitoring and evaluation of the management of IPSs, health service networks, and DTSs in the program target areas; (ii) monitoring of fulfillment by IPSs and DTSs of targets and commitments included in performance agreements and agreements for internal loans that can be forgiven; (iii) evaluation of the impact of program activities in terms of improved quality, efficiency, and financial sustainability of health service networks; and (iv) monitoring and evaluation of progress in implementing the PNPSS.

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[39] The SOGC includes guidelines on proper handling of hospital waste.

2.9 The foregoing will entail development of health care accountability and monitoring systems that can generate regular reports for the public and for the various governmental and nongovernmental agencies in the sector.

4. Component 4. Program management (US$1.13 million)

2.10 This component includes financing for the program coordination unit (PCU), expenses associated with financing the external audit, and financial costs incurred in resource management.

C. Cost and financing

2.11 To estimate the size of the operation, the following factors were taken into account: (i) the need for resources to strengthen networks, based on proposals submitted by subnational entities to the MPS; (ii) the need for resources to develop other components; and (iii) the country's fiscal resources available for the program included in the proposed 2006 budget.[40]

2.12 Based on these criteria, the amount for the first phase was set at US$50 million, which, at the request of the Colombian government, will be wholly financed with Bank resources (see Table 3).

Table 3: Program costs

Component	IDB (US$ 000)	% Total
1. Reorganization of public-sector IPSs	**43,540**	**87.1%**
1.1 Operational reorganization of IPSs	34,155	68.3%
1.2 Network redesign and modernization	9,385	18.8%
2. Implementation of priority projects of the PNPSS	**2,150**	**4.3%**
3. Monitoring and evaluation	**1,259**	**2.5%**
4. Program management	**1,135**	**2.3%**
4.1 Project Coordinating Unit	667	**1.3%**
4.2 Audits and financial management	468	**1.0%**
5. Contingencies	**1,916**	**3.8%**
Grand total	**50,000**	**100.0%**

[40] The amount for program phase I is 0.2% of the country's annual spending on health care.

III. PROGRAM EXECUTION

A. Borrower and executing agency

3.1 The borrower will be the Republic of Colombia. The Ministry of Social Protection (MPS) will serve as executing agency, acting through the program coordination unit (PCU) being established by program 1525/OC-CO, which in turn is accountable to the MPS General Office on Service Quality. The PCU will be responsible for coordinating, managing, supervising, and ensuring execution and proper use of program resources, as described in the Operating Regulations.

B. Program execution and management

3.2 Program management will be the responsibility of the PCU, which has a team of about eight professionals responsible for the program's technical, administrative, legal, financial, and accounting aspects. The PCU will commission the program audit in accordance with Bank policies.

1. Execution of subcomponent 1.1: Operational reorganization of IPSs

3.3 Activities under this subcomponent will be carried out using the same approach as in operation 1525/OC-CO.

3.4 **Prerequisites for participation of subnational entities and IPSs.** Subnational entities and IPSs wishing to participate in the program must formally state their intention to do so and prepare the studies to assess health care services in their jurisdiction, a network organization proposal including a financial analysis, and an IPS reorganization proposal. These diagnostic assessments will be prepared by each DTS, with technical assistance from the MPS. A model assessment was included in the Operating Regulations. The MPS, in consultation with the DNP and in view of the fiscal evaluation performed by the Ministry of Finance (MHCP) of each subnational entity, will evaluate the diagnostic assessments prepared by each DTS and will target and prioritize the proposals submitted by subnational entities for the purpose of distributing resources.

3.5 **Targeting and prioritization of subnational entities.** Proposals will be selected according to the following prioritization criteria: (i) percentage of population uninsured; (ii) deficit level; (iii) level of dependence on resources to serve poor people not covered by demand subsidies; (iv) percentage of spending on staff services; (v) better sustainability over the middle term; (vi) higher cost-benefit ratio and impact on the network; and (vii) strategic importance in health care provision. Other criteria to be taken into account include the cofinancing proposed by the subnational entity and its track record in meeting commitments with the national government in similar hospital reorganization processes.

3.6 **Performance agreements.** Activities under this component will be executed pursuant to performance agreements between the MPS and subnational entities. The agreements will include three components: (i) a matrix of eligibility for loan forgiveness setting forth the conditions to be met by the subnational entity, including network sustainability; (ii) performance agreements between the subnational entity and the respective IPSs, including a performance evaluation matrix for participating IPSs in each subnational entity that sets baseline values and performance targets; and (iii) an agreement for a forgivable internal loan, to finance the payment of outstanding wages, severance, and social benefits as a result of downsizing.

3.7 As described in the Operating Regulations, the order for accessing program resources will be as follows: (i) after the subnational entity is selected, it signs a performance agreement with the MPS; (ii) after the agreement is signed, the subnational entity signs a performance agreement with each participating IPS; and (iii) lastly, the MHCP signs the internal loan agreement with the subnational entity. Disbursements will be processed by the MHCP with authorization from the MPS to an entity responsible for direct payments to end beneficiaries (staff laid off), pursuant to Bank policies.

3.8 Additional responsibilities of the subnational entities are specified in the performance agreement. These responsibilities include: (i) providing documentation needed for project monitoring; (ii) certifying the fulfillment of legal requirements to streamline staff and certifying that job reductions have been carried out in accordance with the law; and (iii) adopting the technical, administrative, and financial measures to effectively execute, monitor, and audit the program. For the purposes of managing the resources for paying outstanding wages, severance, and social benefits of staff members to be laid off as part of the downsizing of staff, a special bank account will be opened, as described in the Operating Regulations.

3.9 The subnational entity, acting through the DTS, will also be responsible for: (i) forming a team to provide technical assistance to IPSs to meet the targets in the evaluation matrix; (ii) measuring and monitoring progress on the indicators in the evaluation matrix and the IPSs, and reporting on this progress to MPS-PCU on a semiannual basis; (iii) financing accumulated liabilities,[41] for which the use of program funds will not be approved; (iv) carrying out other activities to help meet the targets in the evaluation matrix; and (v) meeting the proposed and approved sustainability targets for the public network. To carry out these activities, the MPS-PCU will provide technical assistance, both directly and through third-party firms, nongovernmental organizations, or consultants hired by the PCU. To ensure that the procedures, criteria, and indicators set forth in the Operating

[41] As described in paragraph 1.31.

Regulations are met for performance agreements, these agreements must be submitted to the Bank for nonobjection.

3.10 **Agreement for a forgivable internal loan.** This loan will finance the payment of outstanding wages, severance, and social benefits of staff members to be laid off as a result of the downsizing of network IPSs, as identified in the baseline assessment,[42] which will help meet the target indicator for staff adjustment as set forth in the eligibility matrix for forgiveness. The MPS will be responsible for authorizing payment of funds associated with the payment of outstanding wages, severance, and social benefits by the MHCP. Also, the Office of Fiscal Support (DAF) will oversee the fiscal adjustment process at the subnational level; the Office of Public Credit and the National Treasury (DGCPTN) will authorize loan agreements for subnational entities; and the Debt Service Division of the DGCPTN will confirm whether the subnational entity's financial status vis-à-vis the national government is up to date.

3.11 **Loan forgiveness eligibility matrix for subnational entities.** This matrix sets baseline values that are generated from the assessments and annual targets for the following performance indicators for a 10-year period: (i) adjustment and maintenance of staff size according to demand, through severance payments and savings as a result of the adjustment; (ii) spending cuts and financial sustainability; (iii) service output; (iv) quality of medical services; (v) management of IPSs; (vi) management of subnational entities (DTSs); and (vii) debt relief. Detailed descriptions of these indicators are available in the Operating Regulations of the program and the logical framework (see Annex I). These targets will be set in negotiating the agreement to be signed between the MPS-PCU and the DTS, based on the diagnostic assessment. The main objective of the performance agreement is to ensure that the IPSs and subnational entities meet these targets.

3.12 **Financial terms of agreements for forgivable internal loans.** The following terms have been agreed on for such agreements: (i) the minimum term will be 10 years; (ii) the interest rate for 90-day fixed-term deposits will be applied;[43] (iii) the loan is to be repaid in nine equal, consecutive annual installments, including principal and interest; (iv) the grace period will be two years; and (v) in the event of nonpayment, the following sources will be used for repayment: (a) first, the resources of the SGP, pursuant to Law 715 of 2001;[44] and (b) if necessary,

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[42] The list of positions to be eliminated is part of the departmental proposal for IPS reorganization, based on the diagnostic assessment, and is also part of the performance agreement.

[43] This interest rate is the rate charged by the DAF to the MHCP for adjustment loans to subnational entities. This rate ensures the "profitability" of loans by the national government, as required under Decree-Law 1133/99.

[44] The health care resources of the SGP for a fiscal year represent 10 times the amount of the internal loan contracts, and therefore will not represent a significant expense for the SGP.

resources from any other subnational entities that the MHCP-DAF may identify to repay the loan.[45]

3.13 **Evaluation of agreements for forgivable internal loans.** Each year, at least three months before the due date for each installment of the loan repayment, the forgiveness eligibility matrices for the performance agreements will be evaluated by a committee consisting of representatives of the MPS, MHCP, and DNP to determine whether the installment in question is forgivable.[46] If the targets set forth in the forgiveness eligibility matrix for each IPS have been met as of the evaluation date, the respective installment for each IPS under the internal loan agreement will be forgiven. If the targets in the forgiveness eligibility matrix are not met, the respective installment of the internal loan agreement must be made, in which case the subnational entity should turn to the payment sources mentioned in paragraph 3.12. This evaluation process will be repeated each year for each performance agreement.

3.14 The chance for forgiveness of installments of the loan repayment will act as the primary incentive for subnational entities to pursue actions to resize and modernize their networks for the purpose of improving service quality and coverage by using resources more efficiently. Moreover, these loans will not influence the solvency and sustainability indicators in the Subnational Debt Law as long as adjustment targets are met in accordance with the schedule in the performance agreement. Subnational entities would thus have an additional incentive to meet the targets set forth in the performance agreement, since failure to do so could hurt their ability to secure future loans.

3.15 **Execution of components 2, 3, and 4 and subcomponent 1.2.** The MPS, acting through the PCU, will be responsible for procuring the goods and services being financed under other program components, in accordance with Bank procurement procedures.

C. Recognition of expenditures

3.16 Colombian government authorities have asked to Bank to recognize, against the proceeds from the loan, the expenditures to be made as part of this operation prior to approval of the loan but after 1 April 2006. The maximum amount of expenditures that may be recognized will be US$15 million, which represents 30% of the loan. The Bank will verify the operation's compliance with procurement procedures and policies and with the Operating Regulations. The Bank, acting

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[45] These resources include 70% of the proceeds from the liquor tax, which Law 788 of 2002 earmarks for hospital restructuring.

[46] The monitoring and evaluation program will provide the information needed by the Agreement Evaluation Committee to verify that targets and commitments are being met by the subnational entities participating in the program.

through the Country Office in Colombia, will assist in the most important procurement processes, verifying compliance with Bank procurement policies.

D. Procurement

3.17 The program includes the procurement of goods and consulting services. These goods and services must be procured in accordance with the Policies for the Procurement of Works and Goods Financed by the IDB (GN-2349-6) and the Policies for the Selection and Contracting of Consultants Financed by the IDB (GN-2350-6). Annex II provides the procurement plan for the first 18 months of the project.

3.18 International competitive bidding will be mandatory for the procurement of goods in amounts of US$250,000 or greater; national competitive bidding will apply to goods in amounts between US$50,000 and US$250,000; and shopping will be carried out for goods in amounts less than US$50,000. To procure consulting services in amounts less than US$350,000, short lists consisting solely of local firms may be drawn up.

3.19 **Bank review.** The Bank will follow the review procedure described in documents GN-2349-6 and GN-2350-6. Based on the positive experience in operation 1525/OC-CO,[47] the semiannual post review procedure will apply to goods procured in amounts less than US$250,000 and for consulting services procured in amounts less than US$350,000.

3.20 **Revolving fund**. The revolving fund of 15% of the loan amount, equivalent to US$7.5 million, will be established under Operations Administration policy OA-345. This is supported by an analysis of the disbursement flow based on the program schedule and previous commitments. Disbursements will be made at a vigorous pace from July 2006 to July 2007, when disbursement requests are to be submitted to the Bank at the same time for all IPSs having signed performance agreements. The PCU will submit semiannual reports on the status of the revolving fund within 60 days following the end of each six-month period. This will help determine whether the revolving fund is at an appropriate level. In managing 1525/OC-CO, the PCU successfully used a revolving fund of a comparable amount (US$7.2 million), which aided in the smooth execution of the operation.

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[47] The post reviews (see CCO-4335/2005) show that the PCU's internal control, administrative, financial, and accounting system allows it provide basic and supplementary financial statements in a timely fashion. The external auditors concluded that there are no major weaknesses in the internal control environment and that the executing agency has an appropriate administrative and financial structure.

E. Execution period and disbursement timetable

3.21 The program will have an execution period of 24 months. The disbursement period has been estimated at 36 months, starting on the effective date of the loan contract (see Table 4).

Table 4: Disbursement flow (US$ thousand)

Source	Year 1	Year 2	Year 3	Total
IDB	30,000	15,000	5,000	50,000
%	**60%**	**30%**	**10%**	**100%**

F. External auditing

3.22 The borrower, acting through the PCU, will submit annual financial statements to the Bank throughout the duration of the program within 120 days after the end of each fiscal year. The final program report must be submitted within 120 days after the last disbursement. External audits of the program will be performed in accordance with Bank policies by an independent auditing firm acceptable to the bank, pursuant to the terms of reference for external audits in Bank-funded projects (AF-400). This firm will be selected and hired using the procedures described in document AF-200. Audit costs will be included in program expenses and funded with proceeds from the Bank loan.

G. Monitoring and evaluation

3.23 **Monitoring meetings and evaluations.** The MPS, the PCU, and the Bank will hold monitoring meetings to review the functioning of the program from an institutional and operational point of view. Two semiannual meetings will be held in the first year, and one meeting will be held in each of the following years. The meeting dates will be determined by the Bank and the MPS. Based on the outcomes of the review, appropriate measures, if any, will be adopted to ensure proper progress.

3.24 **Progress reports.** The PCU will submit semiannual progress reports to the Bank during the program, and these reports will contain an appropriate level of detail on activities and progress in each component in terms of disbursements made and targets set forth in the logical framework, as well as the reports by consultants hired under the program.

3.25 **Evaluation.** The program will undergo a final evaluation, to be funded with program resources. To this end, outcome indicators were developed and baseline values and targets will be estimated for indicators in the logical framework (see

Annex I). Indicators associated with the *components* will emphasize progress in program targets, including trimming personnel costs through operational reorganization, maintaining health service output levels, the ratio of the benefits provided to those covered by the subsidized regime to those provided to the uninsured (see paragraph 4.12), and progress in implementing the quality monitoring system at public-sector IPSs and in the accreditation process. *Purpose-level* indicators will measure consumer satisfaction with public-sector IPSs and their financial sustainability. *Goal-level* indicators will measure improvement in access to health care for the poorest population, as achieved by expanding the subsidized regime and improving the quality of health care by reducing the rate of hospital-borne infections.

3.26 To avoid duplications, monitoring and evaluation processes for the proposed operation will be coordinated with those of Operation 1525/OC-CO. The operational reorganization of the IPSs can only be evaluated after a full fiscal year has elapsed after the jobs are eliminated. For example, to evaluate the performance agreements signed in fiscal year 2004, financial and operational information will have to be collected until December 2006, and the outcomes of the evaluation will be available in mid-2007 (see Table 5).

Table 5: Evaluation process for loans 1525/OC-CO and C-L1017

Year	1525/OC-CO	CO-L1017 Phase I	CO-L1017 Phase II
2004	Year zero		
2005			
2006	Baseline. As of December 2004		
2007	Midterm. As of December 2006	Phase II trigger	Phase II baseline
2008			Beginning of Phase II
2009	Final. As of December 2008	Final. As of December 2008	
2010			
2011		Post. As of December 2010	Midterm. As of December 2010
2012			Final. As of December 2011

3.27 The evaluations will start with a baseline, in coordination with the diagnostic assessments and performance agreements at each IPS and subnational entity. This will be followed by annual measurements that will be used to evaluate fulfillment of the conditions in the forgiveness eligibility matrix.

3.28 The government has stated that it will not perform an ex post evaluation. Nonetheless, the data compiled for the program evaluations may serve as a direct

input for the ex post evaluation of the program. The government agrees to collect and make available the information needed to prepare the project completion report, pursuant to Bank policy (OP-305).

IV. VIABILITY AND RISKS

A. Institutional viability

4.1 The program for the reorganization, redesign, and modernization of health service networks is mentioned in Article 43 of Law 812 of 2003, whereby the National Development Plan was approved for the 2003-2006 period.

4.2 The approach for executing component 1—through performance agreements and loan agreements between the national government and the subnational entities—is in accordance with Article 54, paragraph 3, of Law 715 of 2001. This article allows the national government to grant forgivable loans to subnational entities for the program to reorganize and modernize public-sector health service networks, which will be considered sector investment expenditures.[48] Lastly, the successful execution of loan operation 1525/OC-CO confirms that the program is legally viable.

4.3 As for the program's institutional viability, it should be noted that the capacity, stability, and readiness of the PCU involved in implementing the Bank-financed pilot project in 1999 and Program 1525/OC-CO since 2004 are more than satisfactory.

B. Financial viability

4.4 The Government of Colombia has ensured that adequate fiscal resources are available for this program. In the 2006 budget, the MPS has allocated up to 146 billion Colombian pesos (approximately US$70 million) to finance activities for the operational reorganization of public-sector IPSs. On 27 March 2006 the National Economic and Social Policy Council (CONPES) authorized the national government to enter into loan contracts with multilateral banking institutions for up to US$50 million to finance phase I of the program.[49]

4.5 Figure 1 shows the trend toward deficit reduction at public-sector IPSs starting in 2002, which can be attributed to the operational reorganization process that began in 1999. The efforts proposed in this program will yield a substantial reduction in the operational deficit of public-sector IPSs over the medium term. Based on the

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[48] It also provides that: (i) these loans will not be part of the solvency and sustainability indicators of Law 358 of 1997 as long as the entity receiving them does not comply with the national government's conditions for forgiveness; and (ii) if the loans are not forgiven, the SGP's health care revenues may be pledged as collateral to the national government.

[49] See document CONPES 3415. Available in the RE3 project technical files.

fiscal savings projected for 2007-2009, the program's internal rate of return (IRR)[50] is estimated at 15%. If fiscal savings for 2007-2012 are taken into account, the IRR for the program would be 28%. The period for recovering the investment in employee compensation is estimated at two years and three months for the entire program.[51]

C. Environmental and social impact

4.6 **Environmental strategy.** The Colombian regulatory framework for hospital waste management is fairly comprehensive. Noteworthy are the following: (i) Law 9 of 1979 (National Sanitation Code); (ii) Resolution 4445 of 1996, which sets minimum sanitary conditions for hospitals and similar facilities, and regulates the sanitary evacuation and disposal of liquid and solid waste and the control of air emissions; (iii) Decree 2676 of 2000 and Decree 1011 of 2006, which regulate the comprehensive management of hospital waste and other waste; (iv) Resolution 01164 of 2002, providing for the adoption of the Procedural Handbook for the Comprehensive Management of Hospital and Other Waste in Colombia, which was disseminated nationally by the MPS; and (v) Decree 2309 of 2002, which established the SOGC, which includes hospital waste management as part of the single qualification and single accreditation systems.[52]

4.7 Complete information is not currently available on the implementation of these standards. However, as these are part of the standards of the Single Qualification System, it may be surmised that most hospitals comply with the minimum criteria.[53] Because the comprehensive management of hospital waste is included in the accreditation standards, technical-assistance activities were included in component 1 to support the IPSs in managing hospital waste and the DTSs in improving verification, monitoring, and oversight activities.

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[50] This rate is the ratio of expected savings to program costs. It does not reflect related social benefits and costs.

[51] The estimated recovery period is consistent with those seen in similar programs around the world. See: Haltiwanger and Singh. (1999), "Cross-Country Evidence on Public Sector Retrenchment", The World Bank Economic Review, Vol. 13, No. 1, pages 23-66.

[52] The qualification criteria set standards for infrastructure and procedures for holding and storing hazardous biosanitary, anatomopathological, and sharp hospital waste, and for implementing documented procedures for the management of infectious or hazardous hospital waste. The accreditation standards ensure processes for the safe handling of waste, inter alia.

[53] See: Cali Municipal Comptroller's Office. "Informe del Estado de los Recursos Naturales y del Medio Ambiente del Municipio de Santiago de Cali [Status report on natural resources and the environment in the Municipio of Santiago de Cali]," Santiago de Cali, 2003.

4.8 **Social strategy**. Colombia stands out in the region in indigenous health issues.[54] In Colombia, any health care activity planned for indigenous communities must be previously agreed upon with the communities in question and approved by the respective local governments or authorities exercising internal authority in the communities. Law 100 of 1993 introduces affirmative action criteria to help indigenous communities access resources from the subsidized regime, and allows them to exercise local control over the ARSs by developing their own health services.[55]

4.9 Component 1 includes the design and development of training activities and job retraining for people impacted by the operational reorganization of the IPSs. These activities are aimed at lessening the psychological impact of the termination of the employment relationship, promoting the proper use of funds received as compensation, supporting the development of organizational forms such as service cooperatives, and helping to reduce the negative social effects of this process. Currently under development is a study of the job training and retraining activities held as part of program 1525/OC-CO, and proposals will be generated to improve them.

D. Benefits and beneficiaries

4.10 **SEQ and PTI classification**. This operation qualifies as a social equity enhancing project, as described in the indicative targets mandated by the Bank's Eighth Replenishment (document AB-1704). As the operation will improve access to health services that will mostly be used by the poor, this operation qualifies as a poverty-targeting investment.

4.11 The impact of the program in improved access to health care is clearly seen in the increased output of health services after the operational reorganization (see Table 2). Several hospitals that had been closed or could not purchase medicines and supplies due to debt are now open and providing health services. Moreover, it is estimated that more than 70% of the consumers of public-sector hospitals have an income level below the poverty level or live in a municipio where they report at least one basic need as going unmet. This is borne out by the data of the Home Survey of March 2000 and by billing statistics of public-sector IPSs, which indicate

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[54] See: IDB. "Calidad Legislativa Indígena en América Latina. Compilación de Legislación sobre Asuntos Indígenas [Indigenous legislation quality in Latin America: A compilation of legislation on indigenous issues]," SDS/IND, 2003, page 12.

[55] Data from the 2003 Life Quality Survey show that indigenous people in Colombia enjoy preferential access to the subsidized regime (see Bernal and Cardenas, "Race and Ethnic Inequality in Health and Health Care in Colombia", mimeo, 2005).

that in 2005 some 79% of health services were targeted to the poor (45% to the uninsured poor and 34% to the subsidized regime).[56]

E. Risks

4.12 A potential risk of the operation is that IPSs after the operational reorganization might **discriminate against the *uninsured poor***, which would reduce access to health care for the uninsured poor. There is currently no apparent systematic basis in public-sector IPSs against the uninsured. The current incentive system—whereby public-sector IPSs receive payments for providing services to the uninsured as well—will work against this risk. Still, to control this potential risk, the PCU will develop an index comparing the value of services provided to those insured under the subsidized regime to those provided to the uninsured, and will include this index in the monitoring and oversight system. If this index fluctuates in a way not warranted by exogenous factors—such as expansion of the subsidized system, changes in the level of service contracting with ARSs or DTSs, and/or changes in the IPSs' service portfolio—a more thorough analysis will be conducted.

4.13 A potential political risk is that the performance agreements and internal loan agreements to be financed between the national government and subnational entities are to be executed by the new government. However, this risk is satisfactorily mitigated by the sustained demand from subnational entities, as expressed during operation 1525/OC-CO, and by the fact the parties are bound by the agreements for 10 years, a period much longer than the current term of office.

4.14 During operation 1525/OC-CO, Colombian case law expanded the extent to which **special constitutional protection** (Law 790 of 2002) was expected to apply.[57] This creates a risk that will be mitigated: (i) by ensuring that a thorough review of employees' financial condition is conducted as part of ensuring that the proposals for IPS reorganization are viable; decisions on laying off staff may thus be made as part of a review of the entity's financial and social sustainability, with proper legal support to ensure that demands do not later emerge to generate additional expenses and cause difficulties in resizing the institutions; and (ii) by recommending that the subnational entities involved in the program establish the amount of contingent liabilities that would be generated in the health sector as a result of the potential rulings, so that subnational governments may take these liabilities into account and make provisions to cover potential fiscal contingencies.

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[56] A DNP analysis also shows a statistically significant, positive correlation among supply of private health care services, quality of life, and wealth. In other words, private health care services emerge only in locations with a higher quality of life and greater ability to pay.

[57] In Ruling C-044/04 of 27 January 2004, Colombia's Constitutional Court held that the ban on denying service to mothers who are heads of household and have no other financial resources, as provided in Article 12 of Law 790 of 2002, should also apply to fathers who are in a similar situation.

LOGICAL FRAMEWORK

EXPANSION OF THE PROGRAM FOR THE REORGANIZATION, REDESIGN AND MODERNIZATION OF HEALTH SERVICE NETWORKS (CO-L1017)

Narrative summary	Progress indicators	Means of verification	Major assumptions
GOAL			
To help improve the health of the Colombian people.	• Increase coverage of the subsidized regime by 2 million new members between 2006 and 2011.	• Official data from the Ministry of Social Protection (MPS) and National Social Security Council	
	• The hospital-borne infection rate falls from X in 2007 to Y en 2011.[1]	• Hospital recordkeeping system	
	• The neonatal mortality rate falls from 12 per thousand live births for 2000-2005 to 11 per thousand live births for 2005-2010.	• National Population and Health Survey (ENDS) 2005 and 2010	
PURPOSE			***From purpose to goal***
To enhance the efficiency, quality, and financial sustainability of public-sector health service networks.	*By the end of program phase I* • By 2008, 90% of the targeted institutional health care providers (IPSs) are financially stable.[2]	• Budget execution at public hospitals	• The country's macroeconomic profile is stable.
	• Average rate of consumer satisfaction in targeted IPSs rises from X% in 2006 to Y% in 2008.[3]	• Program monitoring and supervision system and program final evaluation	
COMPONENTS			***From components to purpose***
1. Networks of public hospitals redesigned, reorganized, and modernized.	*By the end of program phase I* • Staff costs decline by an average of 15% at IPSs targeted by the program.	• Program monitoring and supervision system and program final evaluation	• Health departments have the tools and procedures to develop IPS qualification processes.

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[1] The indicator baseline and target will be set once the hospital recordkeeping system has been improved.

[2] Financially stable is understood to mean that sales for services cover the operating expenses of the IPS in question.

[3] The baselines and targets will be adjusted in light of the information gathered in setting the baseline.

Narrative summary	Progress indicators	Means of verification	Major assumptions
	• Level of output of hospital services remains constant in the aggregate for all targeted IPSs.[4]	• Program monitoring and supervision system and program final evaluation	• Sufficient levels of connectivity.
	• Output level for outpatient services4 remains constant at all targeted IPSs.	• Program monitoring and supervision system and program final evaluation	• Staff sizes at local health departments are appropriate and stable.
	• At least 80% of the targeted local health departments (DTSs) (an estimated 10) receive training in the service provision component of the accreditation process and meet established standards.	• Program monitoring and supervision system and program final evaluation	• Mayors and governors have the political will and cooperate to adjust and reorganize the health care system in favor of a network approach.
	• Quality control system is implemented at 80% of targeted IPSs.	• Program monitoring and supervision system and program final evaluation	• The legal framework for human resources management remains stable.
	• The index measuring the ratio between the value of benefits provided to those insured under the subsidized regime and those provided to the uninsured remains constant at the targeted IPSs.	• Semiannual program performance monitoring reports	
	By the end of program phase I		
2. Support for the national health care policy	• National health care technology evaluation system has been designed.	• Semiannual program performance monitoring reports	• Health departments have the tools and procedures to develop IPS qualification processes.
	• Regulatory guidelines have been set for the organization of services offered by the public-sector.	• Semiannual program performance monitoring reports	• Sufficient levels of connectivity.
	• Annual quality reports and rankings of IPSs and EPSs are being published	• Semiannual program performance monitoring reports	
	• Percentage of IPSs with connectivity rises from 10% to 20% at level 1, from 20% to 40% at level 2, and from 40% to 80% at level 3.	• Semiannual program performance monitoring reports	
	• Mechanisms have been designed for competency and skills training for support staff.		

a. _____

[4] The output level relates to the fiscal year prior to operational reorganization. This level may shift as a result of the change in the network IPS's service portfolio.

Narrative summary	Progress indicators	Means of verification	Major assumptions
	By the end of program phase I		
3. Monitoring and evaluation	• At least 1 report produced and annual meeting held for monitoring and evaluation of performance agreements.	• Semiannual program performance monitoring reports	• Governors, departmental directors, sectional health departments and IPS managers commit to provide the necessary information.
	• Program final evaluation report produced	• Semiannual program performance monitoring reports	