I. Background

The framework law number 1438 setting the major principles of the new health financing reform in Colombia was enacted on 19 January 2011. The bill number 210-2013 currently under discussion in Parliament committees, once approved, will provide further guidance for implementation and allocation of responsibilities.

In this context, the Government of Colombia requested a 400 million USD loan from the Agence Française de Développement (AFD) to be used for implementing the new health financing reform. AFD plans to mobilize as well the European Commission Latin American Investment Facility (LAIF) to combine technical support funded by a grant with the AFD loan.

In order to better design its technical support and in line with the P4H "inform and involve principle", AFD requested the Groupement d'Intérêt Public – Santé et Protection Sociale Internationale (GIP-SPSI), the Pan American Health Organization (PAHO) and the P4H coordination desk (CD) to participate in the AFD scoping mission.

II. Objectives

The objectives of the P4H CD mission in Colombia were:

1. To contribute to the analysis of the national context
2. To contribute to the analysis of the Colombia health financing reform agenda and the related country support needs
3. To take stock of the current and planned support to be provided by other development partners active in the area of health financing
4. To elaborate recommendations for the support to be provided by AFD and its coordination with the other development partners

III. Results

3.1. The national context

With an estimated 47 million people, Colombia is the third most populous country in Latin America. Average population density is around 41 inhabitants per square kilometre but with huge differences between Andean highlands or Caribbean coast and eastern lowlands (comprising 54% of the national territory but less than 3% of the population). Universal health coverage is much easier to achieve in the densely populated areas than in the Amazon area.

Colombia has a vivid economy that has been growing steadily for the last 40 years (except in 1999-2001). With a GDP per capita of 7,800 USD (nominal), Colombia is now part of the upper middle income countries' group. There is significant fiscal space as general government expenditures account for 29% of GDP. Such macro-

economic conditions are generally favourable to progress towards universal coverage in a financially sustainable manner.

Despite the progress made in terms of economic growth, equity remains a critical issue: the GINI index is one of the highest in the world at 55.9. A significant share of the health needs in particular of the lowest quintiles of the population, are likely to remain unmet.

Since after the 2nd World War, some level of political or criminal insecurity (especially in remote areas) has regularly hit the country. From a political point of view, Colombia is quite different from the majority of Latin American countries: the conservative party that had been ruling for a long period of time with strong popular backing is still in charge. Security and stability still seem to remain the predominant voting factors in Colombia.

The current standard health financing indicators look quite good:

- Total health expenditure / GDP = 6%
- Government health expenditure / general government expenditures = 18%
- Out of pocket expenditures / total health expenditures = 17%
- Population coverage through contributory or subsidized schemes = 93%

The progress made in comparison with the period before the 1993 reform is impressive: at that time, only the formal sector (accounting for 18% of the population) was covered through a classic tripartite social health insurance scheme while high end segments (around 5% of the population) were covered through private insurance. The remaining part of the population (more than 75%) had only access to low quality public health centres and hospitals.

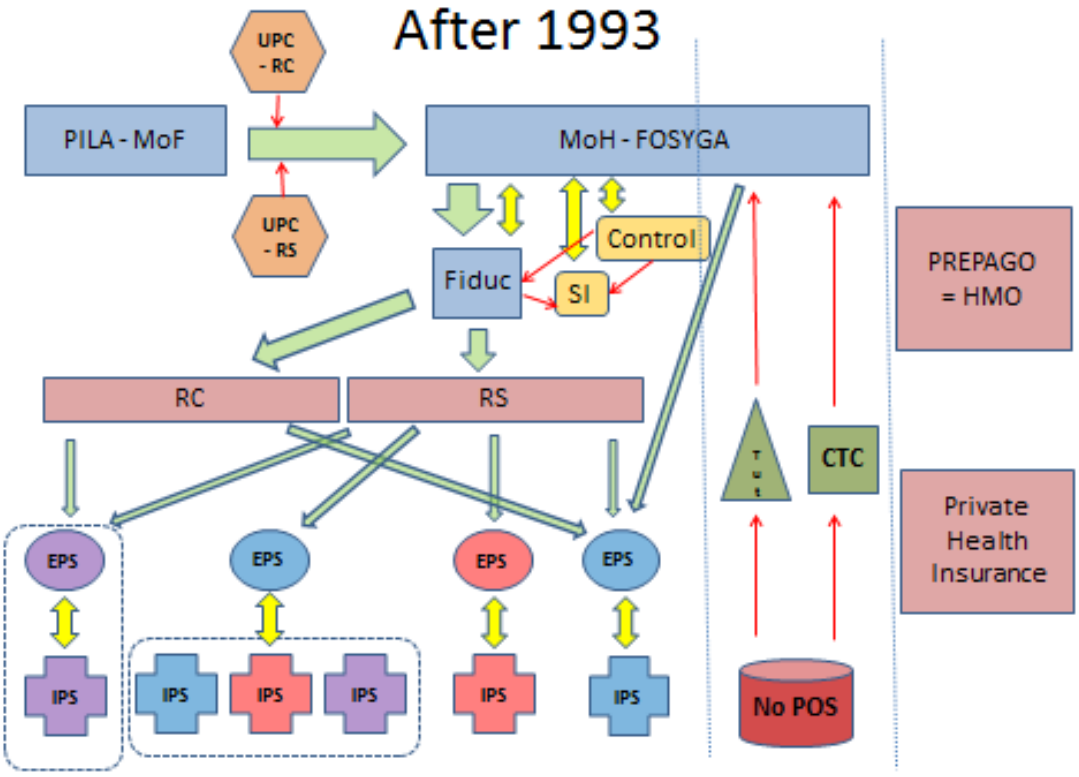
In 1993, the law 100 introduced fundamental changes:

- A market of multiple and supposedly competing public, private for profit and private not for profit insurers (EPS – Entidades Promotoras de Salud) in charge of contracting and paying healthcare providers was created
- Individual enrolment in EPS became mandatory
- A government subsidized scheme (RS – Régimen Subsidiado) was added to the existing contributory one (RC – Régimen Contributivo)
- Two benefit packages (POS – Plan Obligatorio de Salud) and related premiums (UPC – Unidad de Pago por Capitación) were defined for the two RC and RS schemes
- A solidarity fund (FOSYGA – Fondo de Solidaridad y Garantía) was established under the Ministry of Health and Social Protection (MoHSP) to collect all resources for RC and RS and equalize benefits during a transition period

These changes, especially the creation of the RS funded by general government budget and the principle of mandatory enrolment in an EPS, greatly contributed to progressing rapidly towards universal coverage in Colombia. Unfortunately, a number of unexpected challenges gradually emerged as well:

- The managed competition model lead to a high level of fragmentation (more than 60 EPS insurers nationwide) despite the concentration and merging observed since the reform was introduced;
- EPS are increasingly considered as inefficient and sometimes more interested in investing their surpluses in real estate than ensuring good quality of care for their customers;
- The population dissatisfaction with the quality of care provided by the EPS is also related to the frequent vertical integration between EPS and IPS (Instituciones Prestadoras de Servicios de Salud - healthcare providers) derived from the American HMO model;
- In some low population density areas, few or none of the EPS are interested to enroll families and contract healthcare providers (in these areas, very often only low quality public providers do operate);
- The fact that the RC provides better benefits (POS) than the RS has been increasingly considered as unfair;
- Since 2000, several court rulings (confirmed by the Supreme Court in 2008) stated that the definition of both POS are in contradiction with the constitutional right to health, leading to No-POS claims to FOSYGA (Tutelas);
- A constant cost escalation in the Tutelas (a very unequal claiming system requiring barristers, etc.) was observed in the last 10 years;
- All stakeholders showed weak regulatory and institutional capacity and the information system lacks coherence and systematic use of data.

In summary, the Colombian health financing system has become one of the most complicated in the world, as shown below.

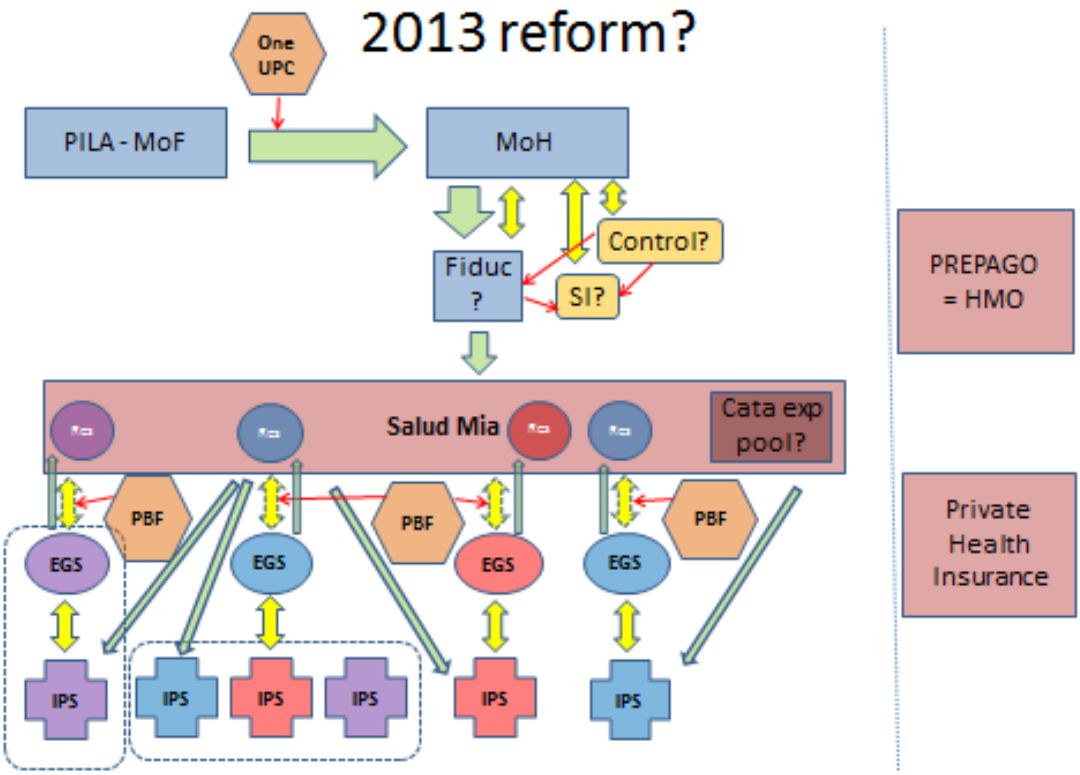


3.2. The health financing reform agenda and related country support needs

The new health financing 2013 reform agenda comprises 6 main pillars:

- The creation of Salud Mia, a new institution centralizing all resources and paying directly the IPS;
- The adoption of Mi Plan, a unified POS for all categories of the population, with a negative definition of services (everything except…);
- The transformation of the EPS into EGS (Entidades Gestoras de Salud), in charge of verifying the services provided by the IPS and giving instructions for Salud Mia payments, remunerated through results based fees;
- The division of the country into coherent "territories", with a limited number of EGS being allowed to operate in each territory;
- The development of a new public health approach focusing on prevention and primary health care and a specific model for remote areas;
- The strengthening of the controlling function, especially through the development of the Superintendencia.

The Colombian health financing system after the 2013 reform could theoretically be described as shown below:



This report will not describe the details of the intended reform as this is already available in other reports but will rather concentrate on a few key issues that remain unclear for the time being and could have a significant impact on the reform process.

The creation of Salud Mia as a new public institution is the first of the two key changes. FOSYGA was only a Ministry of Health and Social Protection sub-account, without legal autonomy and hiring capacity. One would automatically think that Salud Mia is a huge step forward in pooling and risk sharing among all population groups but the design of the reform seems to put serious limitations to this first understanding: Salud Mia will actually keep separate accounts for each EGS and these accounts will not be fungible. The EGS will have to replenish their Salud Mia accounts with their own reserves in case of deficit (EGS account expenditures in Salud Mia higher than UPC x EGS insured people). The EGS accounts in Salud Mia will only be subject to cross-subsidization in case of catastrophic expenditures.

Mi Plan, the unified POS for all categories of the population, is a clear and uncontroversial asset of the planned reform. The main challenge will be its financial sustainability. In comparison to other Latin American countries, the prices of medicines are very high and the use of generics extremely low (less than 3% of total consumption). Colombia has no experience in healthcare services price regulation and many stakeholders are expecting rapidly rising health expenditures after the launching of the reform.

The EPS in Colombia are attracting most of the criticisms and it has therefore been decided for them to stop handling the money spent on healthcare: this is the second of the two key changes. The role of the new EGS replacing the EPS will basically be to verify the reality and the quality of the health services provided by the IPS and to provide clearance for direct payment of these services by Salud Mia. Salud Mia will pay result based fees to the EGS for their work. The key question will be the interest and motivation of EPS to transform into EGS. According to the top management of Compensar (an important not for profit EPS visited during the mission), if the design remains as it is, they would not apply to the EGS status and keep only their IPS activity. Closely related to the issue of the EPS's interest to transform into EGS is the mechanism to determine their fees to be paid by Salud Mia. The Government is clearly announcing that its preference would go for a Performance Based Financing (PBF) mechanism, including indicators related to the health status of the families affiliated by the EGS. This could become a very risky business for the EGS on top of them shouldering as well the potential deficits of their accounts in Salud Mia.

Eventually, the role of the Local Governments Units (LGU) is not clearly defined although they are a key stakeholder for at least two pillars of the reform: the division in "health territories" and the promotion of a new public health approach. A first concern would be the fact that the 10 new health territories do not correspond to any existing administrative borders and that this might further complicate the public health system. The second concern is the lack of involvement of the LGU in the design of these two pillars of the reform whereas they are supposed to be the central implementing agencies.

Following the structure of the reform, the country support needs' main categories could be the following:

- Related to the creation of Salud Mia
  - Organizational Development (structure, implementing rules and regulations, capacity building, etc.)
  - Long term financial projections
  - Improvement of the UPC calculation method
  - Improvement of resource collection techniques
  - Contracting of EGS
  - IPS payment mechanisms
  - Centralized information system
- Related to Mi Plan
  - Definition of the new benefit package
  - Health services categorization and costing
  - Medicine price regulation
- Related to EGS
  - Performance Based Financing schemes
  - Accreditation of healthcare providers' networks
  - Health services quality and cost control
  - Identification of poor families
  - Contracting of IPS
- Related to the health territories
  - Mapping of healthcare services provision
  - Incentives for additional healthcare services provision
  - Public private partnerships
  - Capacity building of the Provincial and District health offices (Secretarias de Salud) and IPS accreditation
- Related to new public health approach
  - Definition of a public primary healthcare model
  - Definition of a specific public health model for remote areas
  - Follow up of chronic diseases at primary level
- Related to controlling
  - Capacity development of the Superintendencia
  - Collaboration between Superintendencia and Secretarias de Salud
  - Auditing procedures

Beyond the structure of the reform, it seems that the launching of a dialogue platform including all national stakeholders involved in the reform could be very useful: such a forum doesn't exist so far and stakeholder exchange in terms of their respective views and interests is limited.

Closely related to the previous point, both the 2013 reform and the Colombian health financing system in general seem to be having governance issues: where are the decisions made? Who is in charge of implementing them? Who will be in charge of monitoring and evaluating the reform process and its impact on the different dimensions of universal health coverage?

3.3. Development partners' current and planned support

PAHO-WHO

Like in all other countries, the PAHO activities in Columbia are following the Country Cooperation Strategy (CCS). In Columbia, the current CCS runs from 2011 to 2014 comprising four strategic thrusts:

- To support the health authorities in developing public policies reducing health inequities;
- To support the strengthening of the Colombian health system, based on primary healthcare in order to improve access to and quality of health services as well as economic sustainability and impact;
- To strengthen interventions reducing demographic, epidemiologic and environmental challenges;
- To strengthen international cooperation in order to achieve better national results and improve Columbia's position in the international community.

More specifically related to the health financing reform, PAHO in Colombia is currently supporting the Government to produce new official National Health Accounts (NHA), using the 2011 System of Health Accounts. The last published Columbian NHA are from the year 2003.

PAHO is also strongly involved in the definition of a new primary healthcare approach by the Government of Columbia and is working in close coordination with the Inter-American Development Bank (IDB) on this issue.

PAHO is also collaborating with USAID and Canada in conflict ridden areas in order to ensure basic health services provision for the inhabitants of these areas.

IDB

IDB has historically been the main partner of the MoHSP in Colombia. Since 1997, three projects helped to improve the network of public health facilities in the country. IDB was also requested to provide a second loan (250 million USD) to the Government of Colombia to funding the health financing reform, in combination with the AFD loan.

At the moment, IDB is supporting the Colombian health system in remote areas in order to develop a specific public health system for these areas: the approach is focusing on primary healthcare (health centres and health posts) and is trying to take into account the unique challenges of these areas. Examples that were given are the respiratory problems of the indigene population or the very low density of inhabitants.

IDB has also provided technical support in the area of the health information system: the examples of SISPRO (a centralized database consolidating various sub information systems) or RIPS (Registro Integral de Prestacion de Salud) were mentioned.

WB

The WB is a rather new partner in the health sector in Columbia but was already involved in the follow up of the Supreme Court rulings about the No-POS coverage through the management of a Norway Trust Fund.

The WB is currently preparing a proposal for Reimbursable Advisory Services comprised of the following main activities:

- Component 1: Salud Mia
  - Supporting the design of new organizational arrangements and strategies to strengthen institutional capacity of central Government to centralize the pooling function.
  - Supporting the development of the main architecture of Salud Mía information system and sub-modules
- Component 2: Bridging financing and provision
  - Knowledge sharing and convening services to inform policy makers on modern financial resource-allocation formulas that can be adapted to the Colombia NHIS for transferring funds from Salud Mía to EGS and providers.
  - Advising on options to manage financial risks of the new approach to the benefit package in the context of Colombia's right to health constitutional mandates.
- Component 3: Improving quality of service provision
  - Developing regulations and guidelines to foster a comprehensive and integrated management of health care with an emphasis on primary health care;
  - Introducing results based financing;
  - Developing a proposal for a National Policy on Electronic and Digital Health Information (E-Health);
  - Developing a roadmap for introducing prospective payments in public hospitals consistent with new Salud Mía and E-Health information policies

USAID and Canada

As already mentioned, USAID and Canada are supporting the provision of basic health services in conflict ridden areas.

Unfortunately, the tight mission schedule did not allow the mission team to visit both offices.

3.4. Recommendations for AFD support and coordination

The first key recommendation to AFD is to enter into a strategic alliance with PAHO-WHO for proposing to the Government of Colombia the establishment of a multisectoral and multi-stakeholders dialogue platform in charge of discussing both the reform content and process and raising the broader issue of the Colombian health financing system governance. This would be in line with the first strategic thrust of WHO 2011-2014 CCS and some support from WHO head office might be available for deploying a health financing policy advisor to organize the work of such a dialogue platform.

The second key recommendation to AFD, in line with the Busan Partnership for Effective Development Cooperation (BPEDC), is to take into account the fact that Colombia could greatly benefit from South-South and triangular cooperation activities in the context of South American integration and recent progress made by emerging countries (Thailand, Mexico, Brazil, China, etc.) towards universal health coverage.

Technically, the areas in which AFD could fill support gaps not yet covered by the other development partners are the following:

- Long term financial projections (Salud Mia and others)
- Design of EGS – Salud Mia contracting system
- Capacity development of EGS in the area of quality and cost control
- Contracting of IPS by EGS
- Mapping of healthcare provision (public and private)
- Capacity development of Secretarias de Salud
- Health services categorization, classification and costing
- Medicine price regulation and promotion of generics

Regular coordination of development partners' support could be organized locally in partnership between PAHO and AFD.

IV. Follow up

- AFD to circulate technical reports
- AFD to contact PAHO-WHO to discuss the strategic alliance and the institutional and funding arrangement for a health financing policy advisor
- PAHO and AFD to call for an open health financing development partners meeting in Colombia
- P4H CD to enquire about USAID's future plans in Colombia