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Colombia Case Study: The Subsidized Regime of Colombia's National Health Insurance System

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Human Development Network

Universal Health Coverage Studies Series (UNICO)
UNICO Studies Series No. 15

UNICO Studies Series 15

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Fernando Montenegro Torres and Oscar Bernal Acevedo

The World Bank, Washington DC, January 2013

¹ This case study was developed using inputs from discussions and background papers that were part of the activities financed by the World Bank’s Nordic Trust Fund (First Phase). These inputs and discussions with experts and government authorities took place within the framework of World Bank’s Programmatic Knowledge Services “Improving the Performance of Social Services.” The case study is based on the inputs for the Universal Coverage Challenge Program (UNICO) Survey developed by PROESA at University ICESI in Cali, Colombia, and on the inputs of Dr. Oscar Bernal, Director of the Master’s in Public Health Program at the University Los Andes, in Bogotá, Colombia, who conducted the UNICAT Pilot Survey for UNICO. The case study also draws on various World Bank background documents for the Policy Dialogue and on the First and Second Development Policy Lending (DPL) on Growth Resilience and Fiscal Sustainability. The authors would like to thank Ramiro Guerrero, Director of the Research Center for Social Protection and Health Economics at the Universidad ICESI in Cali, Colombia (PROESA); Dov Chernichovsky, Director of the Health Program at the Taub Center in Israel; and Adam Wagstaff, Research Manager of the Human Development and Public Services team in the Development Research Group, who provided critical reviews. The authors especially acknowledge their colleagues working on UNICO, particularly Daniel Cotlear, for his insightful and critical questions, and those of the Nordic Trust Fund on Health and Human Rights in Colombia, Andre Medici and Siobhan McInerney, who had the vision and courage to use the grant in a most constructive and creative way to address delicate topics of public policy with technical inputs of the highest quality. The authors are grateful to all.

The World Bank’s Universal Health Coverage Studies Series (UNICO)

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

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Abbreviations

CR	Contributory Regime
CRESS	Comisión Reguladora del Sector Salud
DNP	National Planning Department, Departamento Nacional de Planificación
EPSs	Health Plans (fund holders), Empresas Promotoras de Salud
ESE	Public Health Care Providers, Empresas Sociales del Estado
FOSYGA	Solidarity and Guarantee Fund, Fondo de Solidaridad y Garantía
IPS	Health Care Providers, Instituciones Prestadoras de Servicios de Salud
MBP	Mandatory Benefit Package
MDGs	Millennium Development Goals
PROESA	Research Center for Social Protection and Health Economics at the Universidad ICESI in Cali, Colombia; Centro de Estudios en Protección Social y Economía de la Salud
SISBEN	Social Service Beneficiaries' Identification System, Sistema de Identificación de los Beneficiarios de los Servicios Sociales
SR	Subsidized Regime

Executive Summary

This case study provides an overview of the contribution of Colombia's compulsory health insurance, particularly its Subsidized Regime (SR), to universal health care coverage in the country, and the current challenges the SR faces. The case study is based on discussions with stakeholders from academia and the public and private sectors. Key policy issues presented here were part of a policy dialogue conducted within the framework of the knowledge and convening services program of activities financed with resources from the World Bank's Nordic Trust Fund for Development and Human Rights.

In the early 1990s, Colombia launched a major health sector reform establishing a compulsory health insurance system with two main regimes: the Contributory Regime (CR) and the Subsidized Regime. The reform aimed at introducing a managed competition model where private health insurance was supposed to foster efficiency, quality, and cost containment. The CR was designed to cover all individuals in the formal sector and their dependents. Individuals without any health insurance coverage have access to ambulatory and inpatient services through the public hospital network managed by municipalities. Individuals eligible for CR and SR have health insurance coverage provided by health plans known as (Empresas Promotoras de Salud, (EPS)).² The EPSs organize the delivery of health services through a variety of arrangements that include contracting with individual public and private health care providers.

The SR is a pillar of Colombia's effort to achieve the right to health care as established by the Constitution of 1991, which placed a renewed emphasis on civil rights. The constitution makes the central government responsible for guaranteeing the provision of health services for the population. To operationalize this constitutional mandate, Law 100 was passed in 1993. Controversial since its inception, key stakeholders have engaged in sometimes highly divisive, polarizing debates, with stakeholders defending positions rather than shedding light on obstacles and solutions or building a constructive policy dialogue. As the country emerges from a focus on national security and moves on to tackle a broader spectrum of national priorities and development issues, the health sector reform remains hotly debated. However, a new generation of stakeholders, researchers, and policy makers is clearing the air, creating more transparent and collaborative spaces for a more productive and pragmatic dialogue.

In the last 20 years, health outcomes and access to health care services have improved considerably, and yet there is a widespread perception that the SR, in particular, is at a crossroads, facing major challenges in its responsiveness and financial sustainability. While Colombia has experienced notable economic growth, contributing to poverty reduction over the last decade, income inequalities persist and poverty levels remain high. Income inequalities have contributed to mixed results and progress in the health sector. A top priority in the health sector is the development of a comprehensive legal framework that includes a Health Sector Statutory Law, which is a higher-order law in between an ordinary law and the constitution. A complementary ordinary law will need to capture key technical aspects on the health care model

² The generic term EPS includes a variety of public and private health plans acting as fund holders and governed by a broad set of regulations and norms depending on their specific legal form. By 2010, there were about 70 EPSs nationwide.

including the development of health care networks that can provide comprehensive health care and specialized inpatient and outpatient services as well as a framework for the future role of existing health plans.

The SR health insurance now covers the majority of the population outside the formal sector, but supply-side constraints remain an important obstacle to achieving substantial reductions in inequalities in access to quality services. Large groups of the population face barriers to access due to lack of integrated networks of services, even to some basic primary health care services. The Colombia health system has been moving toward enhanced access to key health services and public interventions, but important regional differences remain a challenge. Legal and regulatory loopholes and gaps need to be addressed to improve regional differences in access and to improve progressivity of subsidies for an important set of ambulatory health care services. Finally, although Colombia offers a wealth of data, little information is systematically used for improving decision making regarding financing and health system performance.

1. Country Context and Health Outcomes

From 2002 to 2007, Colombia experienced an average annual growth rate of 5 percent, largely driven by an improved security situation and a favorable external environment. While economic growth slowed in 2008 and 2009, real GDP growth in 2010 began to accelerate again with a growth rate of 4.3 percent. Economic growth over the last decade has been accompanied by poverty reduction. Between 2002 and 2009, poverty fell from 53.7 to 45.5 percent, while the proportion of the population that could not satisfy basic nutritional needs (the extreme poor) declined from 19.7 to 16.4 percent. The World Bank Human Opportunity Index indicates that between 1997 and 2008, there was significant progress in some social indicators. Advances took place particularly in terms of improving children’s opportunities to access basic health services, attending preschool, completing middle and high school, and having access to electricity and telephones. Between 1995 and 2009, life expectancy increased from 65 to 70 years for men and 74 to 77 for women, while fertility rates fell from 2.9 to 2.4. While these have been positive developments, poverty levels remain high relative to income per capita (US\$9,392 in 2010 purchasing power parity), which can be largely attributed to the unequal distribution of income. Between 2003 and 2009, the Gini Coefficient increased from 0.573 to 0.578. The Gini Coefficient is the seventh-highest in the world (World Bank 2012), showing the stark inequalities in income distribution.

Table 1 Basic Demographic Data, Colombia, 1995–2009

Indicator	Unit	1995	2000	2005	2009
Population	Total (in millions)	36.5	39.8	43.5	45.7
	Growth (annual percent)	1.8	1.7	1.5	1.4
Crude birth rate	Number of births per 1,000 population	25	23	21	20
Crude death rate	Number of deaths per 1,000 population	6	6	6	6
Total fertility rate	Number of births per female	2.9	2.6	2.5	2.4

Sources: World Bank and WHO.

Income inequalities have contributed to mixed results and progress in the health sector, as evidenced by the Millennium Development Goals (MDGs) outcomes. Acute respiratory infections and acute diarrheal diseases, under-five child mortality, and infant mortality have declined over the last decade, nearly reaching the 2015 MDG goal. However, maternal mortality remains high, largely due to indirect obstetric causes and hemorrhages and other preventable causes (table 2). Colombia also ranks low—22nd, just above Guatemala, Nicaragua, Paraguay, and Bolivia—compared with other countries in the region in antiretroviral coverage for individuals with HIV/AIDS who are in need of pharmaceutical treatment. Important regional differences exist at the national level on access to primary health care, health promotion, and prevention interventions.

Transmissible diseases such as malaria have not been properly tackled in rural and remote areas, and other diseases are becoming an important challenge in urban areas. Congenital syphilis increased from 0.9 cases per 1,000 in 1998 to 2.89 per 1,000 births in 2010 (INS 2011). The prevalence of dengue in Colombia increased from 27.5 cases to 157.2 cases per 100,000

inhabitants between 2004 and 2010, and in 2011, the Colombia National Health Institute reported one of the highest number of deaths from dengue in several years (INS 2011).

Table 2 Selected Health Outcome Indicators, Colombia, 1995–2010

Indicator	1995	2000	2005	2010
Life expectancy at birth, total ^a	69.4	71.0	72.3	73.4
Life expectancy at birth, male ^a	65.4	67.3	68.7	69.9
Life expectancy at birth, female ^a	73.7	74.9	76.1	77.2
Mortality rate, infant (per 1,000 live births) ^a	26.4	22.7	19.4	18.1
Mortality rate, under 5 years of age (per 1,000 live births) ^a	31.6	26.8	22.7	21.7
Mortality, rate, maternal (per 100,000 live births) ^b	130.0	130.0	100.0	92.0
Burden of communicable diseases, maternal, perinatal, and nutritional conditions (% of total DALYs) ^c	23.0	n.a	17.0	n.a
Burden of noncommunicable diseases (% of total DALYs) ^c	55.0	n.a	77.0	n.a
Burden of external causes (% of total DALYs) ^c	22.0	n.a	6.0	n.a

Sources:

a. World Data Bank – WDI and GDF

b. WHO, UNICEF, UNFPA, and World Bank estimates.

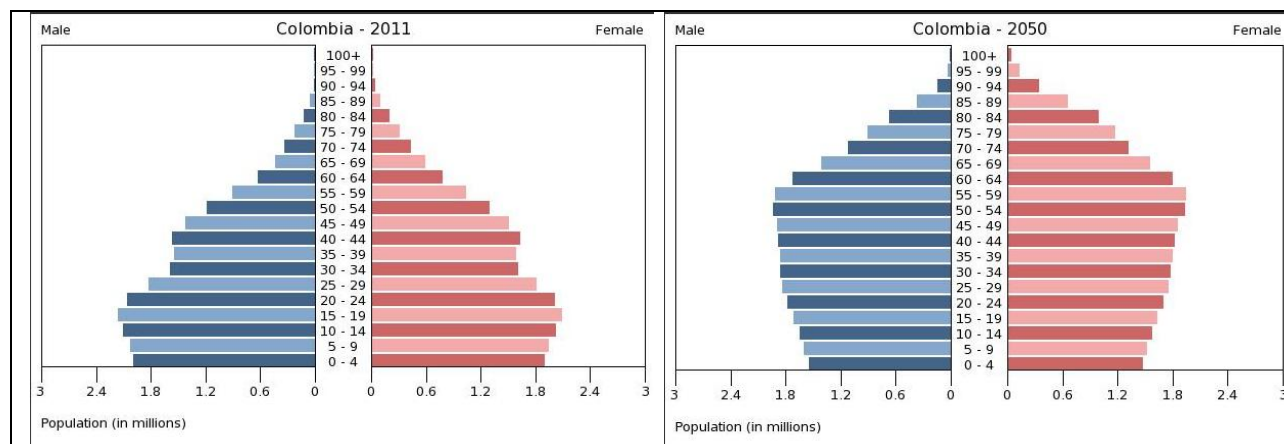
c. Ministry of Social Protection of Colombia

DALYs = Disability Adjusted Life Years. n.a. = not applicable.

Like other countries in the region, Colombia is also facing the challenges of a rapidly aging population. In 2011, 9.2 percent of Colombia’s population was over 60 years old, while only 1 percent was over 80 (United Nations 2011). Demographic projections estimate that by 2050 those numbers could rise to 25.3 percent and 5.8 percent, respectively (see figure 1). This demographic transition is likely to create a significant financial burden on the health system. The treatment of these conditions increases the cost of ambulatory and inpatient care (that is, the demand for long-term use of medicines, more complex diagnostic and monitoring procedures, physical therapy, and so forth). Research has shown that, for example, management of hypertension and pre-hypertensive conditions is much more expensive among the elderly (Roberts and Small 2002). The number of multiple chronic conditions and complications also tend to increase costs of treatment among older adults and the elderly (Abegunde, 2007).

At the same time, chronic and noncommunicable diseases are on the rise, putting an additional burden on the capacity of Colombia’s health system. Between 2005 and 2010, hypertension disorders among adults (aged 18 to 54) increased from 11.9 to 12.6 percent, cardiovascular diseases increased from 55.6 to 61.4 percent, and diabetes increased from 14.8 to 16.5 percent. Moreover, the prevalence of obesity between 2005 and 2010 increased from 13.7 to 16.5 percent and the percent of overweight population increased from 32.3 to 34.6 percent (Profamilia 2010). As risk factors increase, the mortality causes associated with chronic, noncommunicable diseases have also increased. In 2008, among the 10 principal mortality causes, six were related to noncommunicable diseases (PAHO 2010). These conditions affect an important share of the elderly, a highly vulnerable group among the poor. Colombia has the second-highest rate of old age poverty rates in Latin America and the Caribbean (Cotlear 2011).

Figure 1 Demographic Transition in Colombia, Estimated Population Pyramids, 2011 and 2050



Source: U.S. Census Bureau, International Database.

Establishment of the Subsidized Regime as a Pillar of the General Health Insurance System

Law 100, passed in 1993, overhauled the entire health system by establishing a national compulsory health insurance system. The law was a “big bang” reform that introduced an entirely new universal health insurance model based on managed competition. The reform conceptually was originally inspired by Alain Enthoven’s ideas and the Dutch health insurance model. The health care managed competition model in Colombia aimed at harnessing market forces through large-scale participation of the private sector in what was supposed to be a regulated health insurance market created with the separation of purchasing and providing functions embodied in health plans that were financed with public funds, but would purchase health services with public and private providers. Simultaneously, the implementation of a decentralization process expanded by the Constitution of 1991 took place. Within the framework of that public sector reform, the central government decentralized the delivery and pooling of public funds for delivery of key social services, such as education and health, to local governments. After the health sector reform was implemented, the central government stopped providing any public health services, and all health facilities were finally transferred to the more than 1,000 municipalities and *Departamentos* (state-level governments) across the country.

The General Social Health Insurance System (Sistema General de Seguro de Salud Social) was designed to cover the majority of the population through two main social insurance arrangements for the formal and informal sectors. The General Social Health Insurance System established the Subsidized Regime to provide health insurance coverage of poor individuals and those outside the formal sector, while the Contributory Regime was designed to cover individuals in the formal sector. The benefits packages were different, with the CR being far more generous than the SR, which only covered basic primary health care services and selected high-cost catastrophic services. The rest of the services not covered by the Mandatory Benefit Package (MBP) were provided by public sector providers contracted by municipalities. The purchasing function for both regimes was delegated by the national government to public and private entities (and in a few cases a public-private mix of entities). In the case of the SR, the purchasing function was delegated to the municipalities first as part of the decentralization, which in turn also delegated

the purchasing function for the MBP of the SR to health plans. For the CR, it was delegated to EPSs only.

Policy makers expected that the private sector would foster more choices and competition among providers, but for a large share of the poor in the SR, public providers have been and remain the only available providers. The expectation was also that private sector managers of health plans would introduce strategic purchasing in negotiated contracts with Health Care Providers (Instituciones Prestadoras de Servicios, IPS). The old Social Security was converted into a public sector EPS managed as an autonomous public-private sector enterprise. Public hospitals could establish competitive contracts with private and public insurances. By 2010, there were about 70 EPSs nationwide, 21 EPSs in the Contributory Regime, and the rest were in the Subsidized Regime (Bernal and Gutiérrez 2012). Yet, private sector providers limited expansion of facilities outside large urban metropolitan areas. Currently, 70 percent of health providers continue to be essentially the only provider available for SR enrollees in rural areas (Superintendencia de Salud 2012).

Over time, the General Social Health Insurance System institutional setup became highly fragmented and the legal and regulatory frameworks exceedingly intricate and sometimes inconsistent. The federal government has several responsibilities including the regulation, financing, and pooling functions. However, the extremely large number of laws, decrees, legal and regulatory modifications, and other agreements poses various challenges to the supervision of health plans and providers. Furthermore, until 2011, there was virtually no financial supervision of health plans, which were supposed to be monitored by the Health Superintendence. Because the Health Superintendence lacked sufficient staff, resources, and skills to provide adequate financial supervision, since 2011, the Superintendence of Finance has taken over this function.

The architectural framework of the SR is even more complex because of what can be described as a double fragmentation. A vertical fragmentation is produced by decentralization of implementation of the SR at the municipal level, since local authorities were charged with the administrative and fiduciary responsibility of managing both supply-side and demand-side subsidies financed with resources from federal, departmental, and municipal sources. However, on the ground, the actual implementation of SR health insurance coverage is left to the municipalities and to a lesser extent the states (*departamentos*). Other public health services are to be provided by public entities (Empresas Sociales del Estado, ESEs) organized by states and municipalities. A horizontal fragmentation occurred when purchasing of SR health insurance benefits was delegated to EPSs, and the rest (the majority) of services was left to municipalities' contracts with their public health units (Chernichovsky, Guerrero, and Martinez 2012).

In 2008, the Constitutional Court issued a landmark ruling—*Sentencia T-760*—which established a Health Bill of Rights in Colombia. This ruling stipulates that the Colombian government must protect all citizens under the following five circumstances: (a) health services are not delivered because of the patient's inability to pay, including for catastrophic or high-cost procedures; (b) health services are stopped without clear medical reasons; (c) patients do not receive adequate information about their treatment options; (d) patients face unnecessarily burdensome bureaucracy or administrative procedures that might prevent access to services; and

(e) patients are asked to pay separately for services that are part of an integrated treatment plan. The jurisprudence and rulings have been developed within the framework of the Health Reform introduced in 1993 (Law 100) and the Constitution of 1991. In essence, the Constitutional Court called on the executive and legislative branches of the government to fill a void in the stewardship of the health sector and gaps in the regulatory and legal framework. Key issues that Sentence T-760 contained included launching a progressive unification of the MBP as stipulated in Law 100, accelerating enrolment in health insurance coverage, and developing a statutory law. The statutory law that Sentence T-760 ruled is aimed at providing a link and principles to implement the right to health care. Analysis of public hearings of the Constitutional Court and of the litigation in Colombia suggests that a statutory law complemented with an ordinary law and other key interventions may reduce the negative effects of litigation linked to supply-induced demand (Andia 2012; Lamprea 2012).

Widely publicized public investigations into fraud and corruption of health plans and earlier investigations of municipalities have dramatically eroded public confidence in governance of health system. A review of public disclosure of information and the legal framework of health plans suggests that the complexity of the legal and regulatory framework may impede not only adequate supervision but also enforcement of existing checks and balances mechanisms (PROESA 2012). Fraud and corruption at the municipal level have been reported by the media and investigated by public authorities since the funds started to be pooled by municipalities. Municipal authorities are known for using SR for both fraudulent activities and political clientelism.

In 2011, the government launched a major investigation into suspected fraudulent activities involving one of the largest EPSs and soon after several other investigations followed in other health plans and providers. A large number of individuals from EPSs, providers, and governmental entities have been subpoenaed. The government has intervened directly in the largest private health insurance plan (covering about 4 million individuals), and in other medium-size health plans. Preliminary analysis found a wide variety of fraudulent activity in the processing of claims for the mandatory benefits package including fraudulent use of identities, fraudulent enrolments, payments in cases of false diagnosis, and fake documentation to simulate provision of services rendered. Press reports suggest that sophisticated fraudulent activity was carried by the largest private firm EPSs. In addition, authorities have charged various health plan corporations with monopolistic practices and fined various firms and individuals, delivering a new blow to public confidence in the transparency and accountability of the organizational and institutional setup.

2. The SR within the Institutional Architecture of the National Health Insurance System

Subsidized Regime: Financing and Pooling

The CR and SR are both financed with public revenues, but through different mechanisms. The CR is financed through earmarked payroll taxes pooled into a single large fund—the Solidarity and Guarantee Fund (Fondo de Solidaridad y Garantía, FOSYGA)—with various accounts. FOSYGA not only works as a cross-subsidization pool among CR enrollees, but also performs as a major cross-subsidy mechanism between the CR and the SR. The SR is financed with a

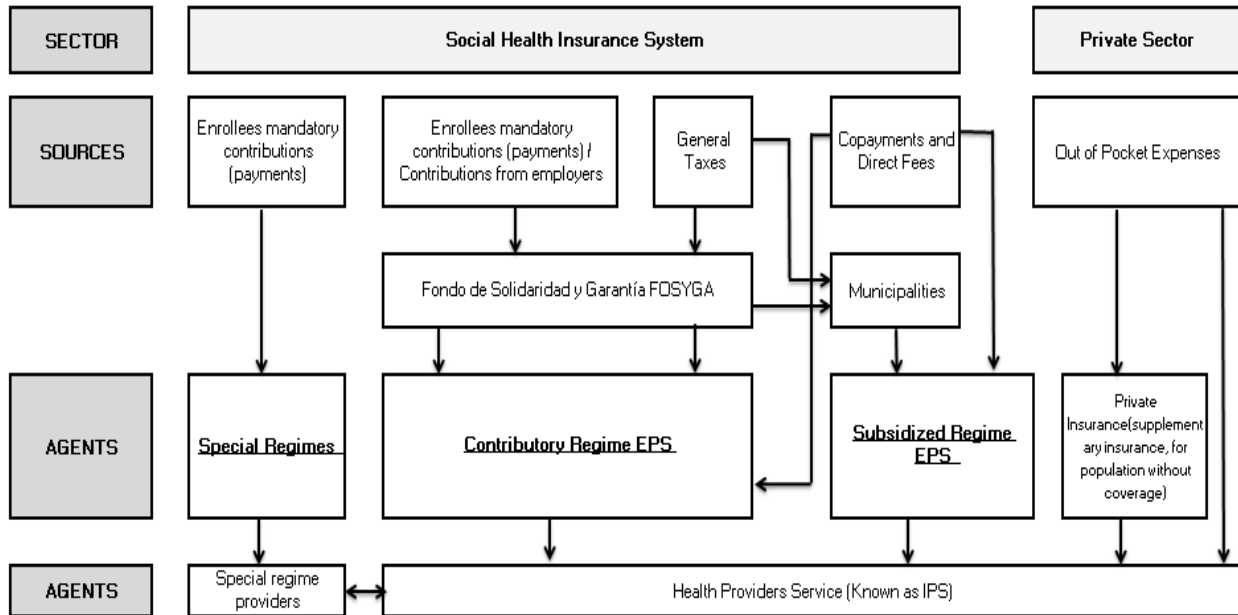
combination of public resources from federal, state, and municipal governments, and the cross-subsidy of the CR (1.5 percent of payroll tax is earmarked for the SR). In 2007, the SR received 49 percent of its funding from the federal government, 36 percent from FOSYGA cross-subsidy transfers, and 14 percent from municipal taxes. Health insurances of both the CR and the SR are paid via capitations established by the government with a formula that does not use individual risk factors or community risk ratings. The formula is based on reported services and costs of the insurance companies. Households can also purchase supplementary health insurance from health plans.

For the SR, the pooling of funds takes place at the municipal level with transfers from fiscal resources³ from the central government and local revenues (figure 2). Municipalities receive fiscal resources as earmarked transfers from the national government to finance health insurance coverage for the SR enrollees of each municipality. The amount of the transfers to each municipality depends on various factors including the population to be covered and other rules from the legal and regulatory framework (Sistema General de Participaciones and Ley de Regalías). The general pooling fund of the CR (FOSYGA) obtains revenues from a solidarity levy on formal sector payrolls (1.5 percent of salaries) and transfers from the national government, and passes them on to municipalities (Arroyave 2009) (figure 3 and table 3).

Municipalities pool all public resources to pay the capitations for the SR to Health Plans and for those services not covered by the MBP contracting directly with Public Health Facilities. The earmarked transfers received from the national government and FOSYGA are pooled into a single fund along with local tax revenues by municipal governments, and the resources are transferred to the health plans on a per capita basis. In some places where municipalities are deemed too small or not capable of managing this process, it is done by the department (provincial government). The capitation paid by municipalities to EPSs is not risk adjusted. The MBP and the amount for the capitations are established at the federal level (by the Comisión Reguladora del Sector Salud [CRESS]).

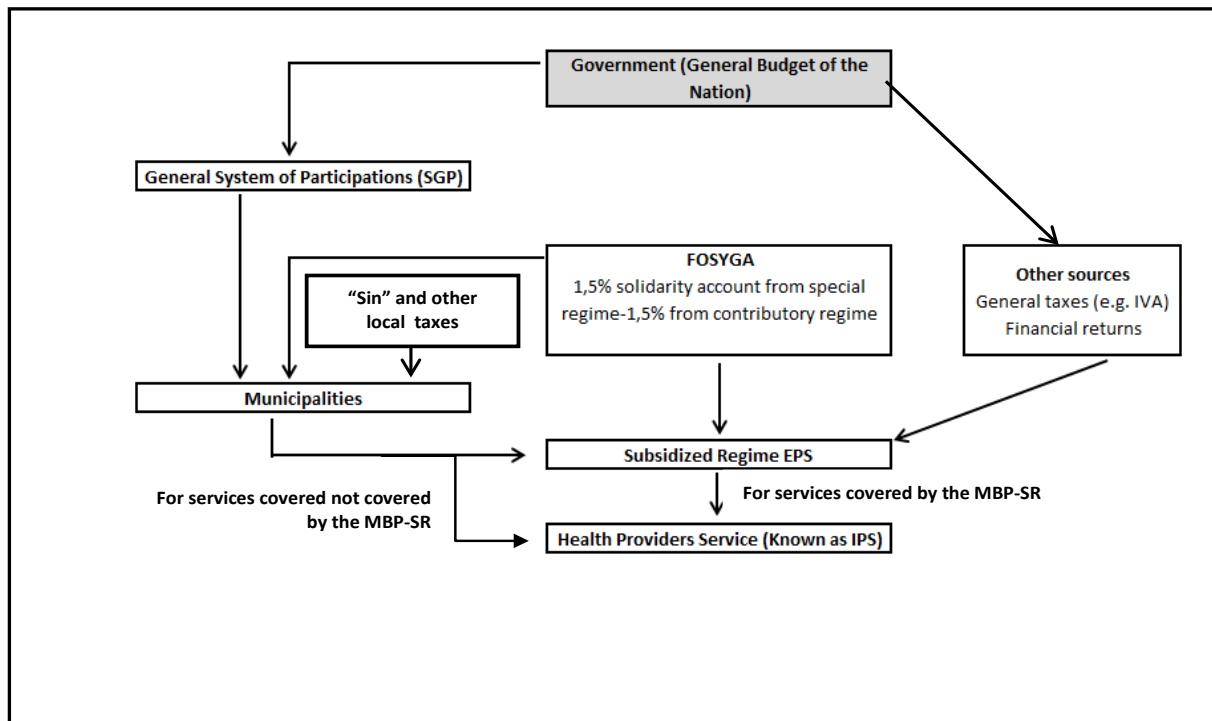
³ Introduced by a law known as the Sistema General de Participaciones.

Figure 2 Subsidized Regime Financing in the National Health Insurance System



Source: PROESA 2012; UNICO Survey Colombia.

Figure 3 Flow of Funds for the Subsidized Regime



Source: PROESA 2012; UNICO Survey Colombia.

Table 3 Organizational Arrangements and Financing for Delivery of Health Care Services in Colombia through Health Insurance Schemes and Public Services

Insurance Arrangements	Target Population	Financial Resources	Health Benefits	Government Responsibility
Contributory Regime (CR)	Formal sector workers and their dependents, autonomous workers with a steady source of income from not poor households.	Earmarked payroll taxes (employers 8.5 percent and employees 4.0 percent) pooled in a compensation fund (FOSYGA).	Comprehensive health benefits package.	Federal level.
Subsidized Regime (SR)	Individuals from poor households without employment in the formal sector, indigenous people and other vulnerable groups.	Fiscal resources from general and earmarked taxes (sin taxes and other). Earmarked payroll taxes pooled in a solidarity fund. Departmental fiscal resources. Municipal revenues.	Limited health benefits package. Only basic services and high-cost catastrophic events. Rest of services provided by municipal public hospitals if approved by a health insurance municipal health authority.	Municipalities (mainly).
Public hospitals and associated primary health care facilities	Individuals enrolled in the SR for accessing services not covered by the SR mandatory package. Individuals who are eligible for the SR but have not yet been enrolled in the SR.	Fiscal resources from general central and local taxes. Contracts with private and public health insurances (EPS of the CR and SR).	Health care services not covered by the mandatory benefits packages of the CR, SR, or other regimes. Emergency services for all the population in need.	Municipalities.
Special Regimes (SRE)	Workers and their dependants from public corporations and autonomous institutions (i.e., armed forces, public oil corporation, etc.)	Payroll contribution of employers and institutions.	Comprehensive health plans and cash benefits differentiated according to the institution.	Public corporations and other autonomous institutions (armed forces, police, National Oil Corporation, etc.).

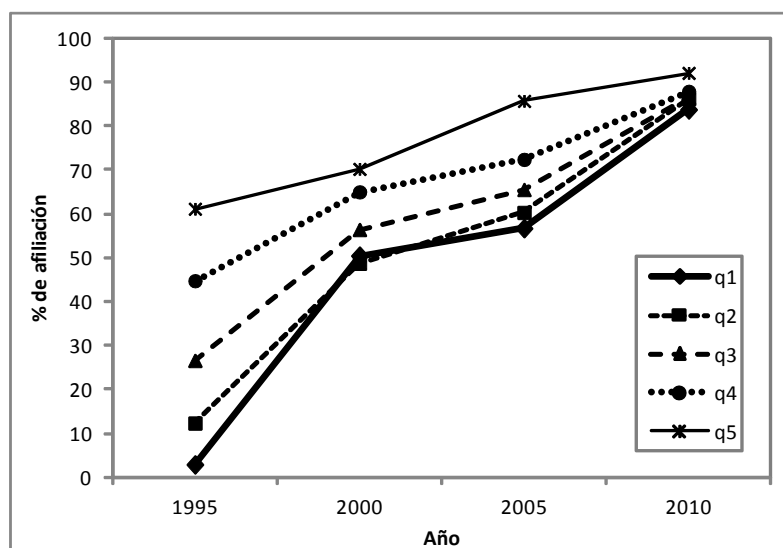
Source: Andre Medici 2012, internal discussion paper, Colombia LCSHH.

Enrolment and Benefits Package

Municipalities and the central government focused in the last 10 years on expanding the enrolment of the SR. As seen in figure 4, the main expansion of enrolment took place among individuals from households in the lowest income quintiles. The poorest strata of the population had very low rates of health insurance enrolment in the early 1990s, and currently have enrolment rates closer to those among individuals from households in the highest quintiles. The

health insurance enrolment gap between rural and urban health insurance affiliation has diminished. In 1997, coverage reached only 58 percent, while in 2010 it had reached 96 percent. As for the poor, coverage in 2003 was 47 percent, and for 2010 the subsidized coverage was 98 percent.

Figure 4 Health Insurance Enrolment by Income Quintile, Colombia, 2000–10



Source: Bernal and Gutiérrez 2012.

Table 4 Individuals Enrolled in Public Medical Insurance, by Regime and Household Income Quintile, Colombia, 2008

Quintile(s)	Regime				
	Contributory (%)	Subsidized (%)	Excluded (%)	Not Enrolled (%)	
All	Share in Population				
	47.0%	38.5	3.7	10.8	
Lowest	Within quintile				
	2.8	27.0	2.2	24.1	
	2	9.3	26.1	5.1	22.2
	3	17.1	22.6	10.2	22.4
	4	28.3	16.2	28.7	18.2
Highest	42.5	8.1	53.7	13.0	
Total	100.0	100.0	100.0	100.0	

Source: Chernichovsky, Medici, and Guerrero 2012.

Table 5 Individuals Enrolled in Public Health Insurance, by Regime and Income Quintile, Colombia, 2011

Quintile(s)	Regime			
	Contributory (%)	Subsidized (%)	Excluded (%)	Not Enrolled (%)
	Share in Population			
All	47.4	39.9	3.9	8.8
	Within Quintile			
Lowest	3.7	28.4	2.1	21.5
2	7.8	23.4	4.5	17.4
3	15.2	19.9	6.7	21.9
4	26.6	18.5	17.3	21.1
Highest	46.7	9.8	69.3	18.1
Total	100.0	100.0	100.0	100.0

Source: Chernichovsky, Medici, and Guerrero 2012.

Policy makers at the federal and municipal level prioritized expansion of enrolment in the SR and moved from the original system of targeting eligibility toward a single health insurance arrangement for all individuals not covered by the CR. Originally, eligibility for SR health insurance coverage used a means proxy test to target the poor who have no employment in the formal sector, and independent workers without a steady source of income (including the near-poor). The Social Service Beneficiaries' Identification System (Sistema de Identificación de los Beneficiarios de los Servicios Sociales, SISBEN) is still used as a general-purpose system for selecting beneficiaries for social programs in Colombia. Municipalities apply a proxy means test (SISBEN) to determine eligibility for various social services. The targeting mechanism used to enroll individuals in the SR, however, was de facto abandoned, because the central government decided to accelerate enrolment and to extend coverage eligibility to all those outside the formal sector. However, individuals must still be enrolled in the SR by each municipality; it is not automatic for those who are eligible (essentially those who are not in the formal sector), but dependant on availability of additional funding and annual enrolment plans.

Expansion of health insurance coverage has been accompanied by plans to reduce payroll taxation and increase fiscal resources for the health insurance system and plans to enhance portability of coverage between the CR and SR. The most recent tax reform proposal specifically seeks to reduce payroll taxes of low-income employees and increase funds from taxes on large firms. It remains to be seen whether this reform will pass, however, since there is a trend to integrate the financing system into a federal-level health insurance pool. Some studies suggest that a significant number of individuals with capacity to pay are enrolled in the SR. One of the studies done by Colombia's Central Bank estimates that 16 percent of the nonpoor are enrolled in the SR (Lasso 2006). Individuals from middle-income households who are self-employed may in the future have fewer incentives to contribute to the CR as benefits differences between the SR and CR are blurred and similar services are offered as part of the unified MBP.

The MBPs and capitations for the SR are currently set at the central level by the Ministry of Health. In recent years, the analysis and decisions on inclusion or exclusion of new services in

the MBP and the estimations for capitations was determined at the national level by the Health Regulatory Commission (Comisión Reguladora del Sector Salud), better known by its Spanish acronym, CRESS. CRESS was a public autonomous entity established in 2007 to collect and analyze data, produce estimates and determine the amount of capitations for each of the regimes, and establish updates to the benefits package. The government abolished CRESS and in December 2012 passed its responsibilities to the Ministry of Health as part of an effort to streamline the institutional arrangements of the health sector.

Since the health sector reform of the early 1990s, the health insurance benefits packages were very different for the CR in that they covered a wide scope of services compared with the SR, which offered a very limited number of services. SR enrollees had access to a limited set of primary care and few high-cost (catastrophic) interventions. Individuals covered by the SR received the bulk of outpatient and inpatient secondary and tertiary level services through public providers contracted by municipalities, and not by EPSs. Law 100 had established that both packages would be progressively harmonized. However, no changes were introduced in more than 15 years despite important rates of economic growth of recent years.

A major change of health insurance coverage occurred when, in 2010, policy makers announced that the unification of MBP would be a health policy priority to be achieved as an important step toward enhanced social equity. Law 100 had originally stipulated that the MBP should be unified progressively, and mandated a deadline of 10 years after the launching of the health sector reform. One of the rulings of the Constitutional Court in 2008 called for the government and legislature to take action and finally implement this part of Law 100 of 1993, which had not been implemented at all. In July 2012, the government passed new regulations calling for health insurance coverage of the same services for all minors under 18 years of age and a year later for all elderly people. Finally, in July 2012 the government passed regulations that called for all citizens to have the same MBP regardless of their health insurance coverage arrangement. The Ministry of Health has estimated that the unification of the MBP will cost COL\$1,400 billion per year (US\$700 billion).

Since all SR beneficiaries have the same MBP as those of the CR according to the new regulations, quality of services and supply-side factors will be the most important constraints on the realization of the right to health care for the poor. Before unification of the MBP, individuals covered by the SR received the bulk of outpatient and inpatient secondary and tertiary level services through public providers contracted by municipalities, and not by EPSs. Outside large metropolitan areas, where medical staff is concentrated, the new right to the same MBP will require progressive investments and human capital to reduce gaps in access to quality health services by the poor. Capitations were estimated and set at a lower amount for the SR to cover the same MBP. The estimates of public authorities were based on a forecast of limited use of services particularly during the first years of implementation of the unification of the MBP. One of the main considerations for this assumption was that actual demand will be low due to well-known constraints on the supply of services and other barriers, which an important share of beneficiaries traditionally have faced. The annual capitation rate for the CR was set at COL\$547,639 (about US\$310), whereas for the SR it was set at COL\$352,329 (about US\$200) (CRESS 2011). In November 2012, however, the Constitutional Court ruled that the base level of capitations for the same MBP should be the same. Thus, calculations of the capitation need to be

refined and modern techniques used for risk adjustment, even for those areas that may end up outside the scope of the managed competition arrangements.

The split of the purchasing and provider responsibilities introduced by health sector reform aimed at improving incentives for strategic purchasing by municipalities and health plans. Public providers were transformed into independent public sector enterprises with their own legal status and ability to establish contracts with both the public and private sector. Municipalities then became purchasers of services not covered by the SR Mandatory Benefit Package, with health services provided by autonomous public providers (supply-side subsidies regime). A transition for public hospitals from supply to demand subsidies had been envisioned since 1993, but it proved to be extremely difficult and protracted given the active opposition of various health sector stakeholders. In July 2012, the government harmonized the MBP, expanding coverage of services to SR enrollees to the same wide scope enjoyed by CR beneficiaries. This major policy change expands, in principle, the role of EPS in the SR, since now almost all services will be financed through demand-side subsidies, drastically reducing the scope of services financed with supply-side subsidies. However, EPSs of the SR are going bankrupt, and those from the CR are reluctant to enroll people from the SR.

The public sector plays a major role in delivering services in Colombia, both for those enrolled in the SR and the uninsured poor. Colombia has 13,840 health facilities, of which 4,466 (32.3 percent) are public and 9,374 (67.7 percent) are private (MPS 2004). Four states and one special district (Antioquia, Atlántico, Santander, Valle del Cauca, and Bogotá DC) have 63.7 percent of the health facilities and approximately 69 percent of the population. Colombia has 43,166 doctors (10.3 doctors per 10,000 inhabitants), mostly concentrated in urban areas. The proportion of doctors in cities with more than 500,000 inhabitants is 23 times higher than in areas with 20,000 inhabitants. The number of hospital beds is steadily declining, from 16,300 beds in 2002 to 13,500 in 2006. The occupancy rate increased from 80.1 percent in 1996 to 86.2 percent in 2006. The public sector provides 40 percent of all outpatient consultations in Colombia. There is an overall growth in the number of consultations; in 2006, the average number of consultations was 15 million and in 2012, 23 million at the first level of care and 4.8 million to 5.3 million at the secondary level of care. The number of admissions at secondary and tertiary level hospitals has remained stable, with 1.1 million admissions per year between 2006 and 2012.

Public hospitals are autonomous entities with the legal capacity to establish contracts with public and private purchasers. Before the reforms were introduced in the 1990s, ambulatory services were included in the public health networks managed by hospitals; currently, however, they are self-standing public entities managed independently and legally capable of establishing contracts with public and private providers. Typically, at the state level, large specialized hospitals are financed by secretaries of health and the rest are financed directly by the municipalities. Coordination of care and development of health care networks remain a challenge to protect the continuum of care and, therefore, the efficiency and quality of care across different levels of care. The 1993 Health Sector Reform also drastically changed the regulation of key inputs across the board in the health sector. There was a radical deregulation of the health care labor market, with salaries left up to negotiations among EPSs, health providers, and individual medical and other staff. Public hospitals maintained some regulation on salaries, labor arrangements, and procurement rules that are not as flexible as the ones of their private counterparts. Medicine

prices were also deregulated, but currently new regulations seek not just to control prices of medicines but also to improve the quality and safety of medicines with other cost-containment mechanisms.

Individuals covered by the SR cannot choose providers because enrollees can access only providers that have contracts with their health plan. Furthermore, individuals effectively have no access to relevant information on quality of providers or health plans or insurance services that could enable them to choose among EPSs. Finally, the transaction costs of changing institutions further prevent competition among health insurances within each regime. There is no portability of health insurance, and clinical and other key information for health care is not shared among EPSs. Therefore, households face many challenges and red tape to get health insurance coverage if they have to move in and out of the formal sector. This factor may negatively affect people in lower-income strata who are likely to be in and out of the formal sector in low-skilled, low-pay jobs.

3. The Subsidized Regime: Considerations on Equity in the Context of the Public Debate on the Right to Health Care in Colombia

In the past, health reform debates in Colombia have been highly polarized, with sometimes very rigid and divisive positions limiting options to exploring approaches to improve the health system. There are, however, signs of an increasingly constructive policy dialogue. Although conceptual and ideological frameworks and implications for Colombia's health system are still published and discussed (Franco-Giraldo 2012), there are also more good-quality data and analysis on key technical issues, such as more refined approaches to the allocation of financial resources (Riascos 2012), or the use of new techniques for a more extensive analysis on equity, or new studies on access and quality of services taking advantage of the most recent household and administrative data.

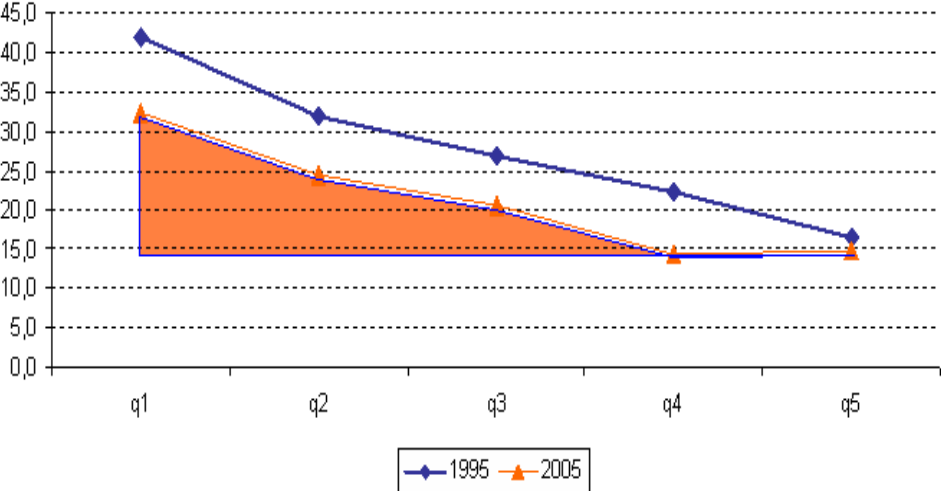
There is also a more open attitude among some key stakeholders to consider alternatives to the managed competition model as it has been implemented in Colombia, particularly for some regions with a large share of poor in their populations. Discussion included in this section focuses only on a few salient issues that have been part of recent discussions on the right to health care in Colombia among public authorities and universities within the framework of activities on knowledge sharing and dissemination financed by the World Bank's Nordic Trust Fund on Human Rights and Development. The idea is to provide value added to the case study by providing some information on topics that the human rights perspective adopted by the Constitutional Court have brought to the attention of policy makers and the overall public debate in which the World Bank has participated.

Despite research suggesting improving trends in equitable access to health care, concern about the slow pace of progress on the right to health care and equity has dominated the public policy debate in the last five years. Key public authorities such as Colombia's Ombudsman, the General Comptroller, the General Attorney, and the more widely known Constitutional Court Magistrates have raised questions about weaknesses in governance and accountability and the legal framework, which are considered to hinder improvements in the efficiency and equity of the health system (Corte Constitucional de Colombia 2012).

Research conducted in recent years suggests that health outcomes overall have improved, but the role of the expansion of SR coverage on improvement of equity is not clear. Some impact evaluation studies, albeit with some data restrictions, suggest that expansion of health insurance coverage in general and of the SR in particular has had a generally positive impact on access to health services among the poor (Giedion and Villar 2009). New research on vital statistics data seems to yield more accurate ranges of some key indicators such as infant mortality (figure 5), but clearly suggests a downward trend with smoother curves over the last 20 years and more dramatic gains in the 1980s (Jaramillo, Chernichovsky, and Jimenez-Moleon 2012). Yet, data also suggest that progress in economic growth has not kept the same pace in the reduction of regional differences in preventable mortality and basic health outcomes.

Health outcomes and use of health services vary significantly by income, health insurance coverage, and geographic location. Infant mortality, for instance, shows a decline from 1995 to 2005, but differences by income were reduced mostly for the fourth and fifth (richest) quintiles (see figure 5 and table 6). Also, individuals enrolled in the contributory regime report using 12 percent more services than those in the SR. About 30 percent of the population considered to need health services reported not using those needed services, 30 percent due to cost and 25 percent due to perceived low quality (Bernal and Gutiérrez 2012).

Figure 5 Changes in Infant Mortality in Colombia by Quintile, 1995–2005



Sources: Ministry of Social Protection 2008. Data on infant mortality from Fundación Corona.

Table 6 Population and Selected Maternal and Child Health Outcome Indicators among Individuals Covered by CR or SR Insurance in Municipalities, Colombia 2008

Indicator	Puerto Arica (Amazonas)	Segovia (Antioquia)	Villa Nueva (Guajira)	Bucaramanga (Santander)	Bogotá (DF)
Population	1,389	38,154	26,219	525,216	7,467,804
Percentage of institutional deliveries	5.9	83.4	41.9	100.0	100.0
Children	63.3	83.4	96.2	100.0	100.0
Infant mortality rate	58.8	25.8	20.0	10.0	15.0

Source: http://www.asivamosensalud.org/index.php?option=com_vector&task=map&Itemid=61.

In the context of a highly deregulated and fragmented health system, effective delivery of key primary health care interventions remains an unresolved challenge since the health sector reform was passed in 1993. There is a solid federal epidemiologic surveillance system that has progressively become more sophisticated in the monitoring, prevention, and control of transmissible diseases. Yet, health promotion and prevention that is financed with earmarked public funds remained a challenge in the last two decades. The effective and efficient delivery of public health interventions and key primary health care services is difficult in a highly fragmented system. Health services are delivered by public and private providers contracting with EPSs from the CR and SR and by municipalities for populations that do not always live within the same geographic boundaries (Bernal and Gutiérrez 2012). This weakens the *continuum* of care delivered by public and private providers and poses obstacles to the poor in rural but also in urban areas, where spending time in moving from one facility to another may represent an important opportunity cost.

Supply-side constraints remain an important bottleneck in various regions, particularly those with low-density population and large rural areas. All physicians are required to work at least one year in rural areas to be licensed by the Medical Boards after graduation from medical school. Nevertheless, important supply-side constraints remain in several states and rural regions of the country (including Amazonia and the Pacific Coast) that generate bottlenecks for the delivery of health care (Medici and Montenegro Torres 2012). Health plans have few incentives to improve delivery of care for enrollees in some regions, despite the allocation of financial resources via capitations to the municipalities and health plans. Lack of institutional capacity and the risk of fraud and corruption have led the government to introduce direct payments to EPSs and public providers for some municipalities (Corte Constitucional 2012).

Since the reform was introduced in 1993, the share of total public spending has increased and private expenditures have decreased. Currently, more than 70 percent of Total National Health Expenditure is public financing—earmarked payroll taxes, fiscal resources, and other public funds (WHO 2012) (table 7). Although out-of-pocket expenditures remain an important source of private spending, overall private spending fluctuates at around 30 percent of Total National Health Expenditures (World Bank 2012), which is considerably lower than many countries in the region. Analysis of catastrophic expenditure suggests that this type of shock to household income became less frequent among individuals from poor families covered by health insurance.

Table 7 Colombia National Health Expenditures 1995–2010

Expenditure ratios	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total expenditure on health (THE) as % of GDP	7.34	8.79	9.57	9.32	9.34	7.31	7.29	7.30	7.69	7.44	7.45	7.33	7.20	6.94	7.59	7.59
General government expenditure on health (GGHE) as % of THE	58.64	64.80	64.88	71.85	76.30	70.75	70.31	70.44	70.05	70.59	70.05	70.84	71.06	70.60	71.06	72.70
Private expenditure on health (PvtHE) as % of THE	41.36	35.20	35.12	28.15	23.70	29.25	29.69	29.56	29.95	29.41	29.95	29.16	28.94	29.40	28.94	27.30
GGHE as % of General government expenditure	19.92	22.88	24.57	24.89	23.15	21.41	18.55	18.98	20.51	19.80	18.98	18.81	18.81	18.81	19.31	20.15
Social security funds as % of GGHE	49.33	50.79	55.70	62.28	63.24	60.22	66.28	63.90	66.03	67.86	69.48	70.11	70.11	70.11	48.61	46.44
Private insurance as % of PvtHE	15.29	14.62	14.10	19.66	27.64	23.32	23.86	22.80	23.41	23.83	23.07	23.87	23.61	23.70	25.15	28.51
Out of pocket expenditure as % of PvtHE	84.71	85.38	85.90	80.34	72.36	76.68	76.14	77.20	76.59	76.17	76.93	76.13	76.39	76.30	74.85	71.49

Source: WHO Country Data, <http://www.who.int/nha/country/col/en>.

Preliminary analysis of new studies on equity and financial protection of Colombia’s subsidies for the health insurance system suggests a lack of progressivity of subsidies for a wide range of ambulatory specialized health care services. Concentration indexes on the use of ambulatory specialized services suggest that subsidies for inpatient care are more progressive than for ambulatory specialized care. The analysis shows that the share of subsidies for individuals from households from the poorest quintile is 16 percent and for those of the second quintile 15 percent. However, the richest quintiles benefit from 28 percent of ambulatory specialized care, making those services all the more inequitable. The analysis of hospital services suggests that subsidies for those services are more equitable, with concentration indexes closer to zero. The poorest quintile share is 18 percent while the richest is 21 percent (Ruiz 2012).

4. Policy Decisions and Key Areas of the Agenda for the Short and Medium Term

A New Comprehensive and Streamlined Legal Framework to Foster Efficiency, Accountability, and Transparency

The government announced as a top priority the development of a comprehensive new legal and regulatory framework that would reform various aspects of Colombia’s approach to universal health coverage. The government has already presented a proposal of a Health Sector Statutory Law, which is set for discussion in Congress and is described as a law “Which regulates the fundamental right to health and creates additional mechanisms for protection.” The proposed law not only defines the limits of the right to health care, but also provides some key principles for the regulation of this fundamental right in the Colombian Constitution. In that sense, the Statutory Law defines the “what” and the ordinary law will have to define the “how.” For

instance, the Statutory Law will need to be considered as the main framework of reference when the executive and legislature develop a new ordinary law for the health sector to establish operational mechanisms to set these limits. Debate is scheduled to begin in early 2013. The government will have to lead the debate on the law already in Congress and seek to build consensus on critical aspects of the proposal while ensuring that its core components can be approved by the Constitutional Court.

In addition to the above-described Statutory Law, an ordinary law, which the government will develop in early 2013, will need to consider key aspects of the ongoing public debate on the health care model and the role of the health plans (EPS). Clarification on the nature and future role of health plans is at the core of some of the most hotly debated aspects of the health care reform. These decisions will have important repercussions on key regulatory aspects such as the new roles in supervision and monitoring that both the Financial Superintendence and the Health Superintendence will exercise at the central and state level. Health authorities and other stakeholders would need to review how their system fits within a spectrum that can range from a pure health insurance model, like the one in the Netherlands, to one that is not considered a traditional health insurance plan, but rather an institution, called Management of Health Care of Israel, both of which are managed competition models.

Financial Sustainability

There is a wide consensus on the need to improve the capitation as a mechanism to pay for health plans. There is no consensus, however, on how to get there, although new initiatives on the introduction of modern risk adjustment techniques are being considered. The Ministry of Health is exploring mechanisms to improve the formula for estimation of the new unified single rate of annual capitations for both the CR and the SR. Health sector authorities need to consider using more sophisticated formulas for risk adjustment that may contribute to better aligning incentives of health plans and providers and reining in unnecessary growth of demand for health care services.

The government is developing new approaches to support municipalities to improve payment mechanisms to health plans and hospitals. Public hospitals managed by municipalities are in the red, and the federal government is publicly committed to providing additional resources to rescue public hospitals. However, the government does not want merely to pump in additional financial resources. Rather, it requires introducing guidelines to standardized accounting systems and other changes that could eventually lead to new ways of paying public hospitals and facilities (Sarmiento and Castellanos 2005). This will contribute also to introducing a new capitation formula with improved risk adjustment approaches and potential use of new forms of prospective payments such as diagnosis related groups. The government has a two-part plan. The immediate goal is to ensure that public hospitals can provide the needed services and thus avoid new hospital closures. The Ministry of Health during 2011 gave an additional COL\$2.2 billion to the health sector of which COL\$436 billion went directly to public hospitals. This adds up to COL\$1.3 billion for the operation of public hospitals from general taxes and COL\$520 billion through direct subsidies.

The government has been paying directly to the public hospitals since 2010, but only the new debts, and therefore the accumulated deficit, still remains a pending issue on the government's agenda. Law 1438, passed in 2011, seeks to enhance medium- and long-term sustainability. According to this law, a National Program for the public establishments is to be developed. This will require the establishment of a special fund with fiscal resources from the central government budget. The objective would be to develop an investment plan to strengthen the capacity of public facilities and modernize their management, with emphasis on the first and second level of care. The Secretary of Health of the special Capital District of Bogotá proposes some solutions for the city that include (a) a standardized list of procedures and administrative costs, (b) joint purchasing, and (c) payment of old EPSs debts in exchange for creating a real network and clarifying the services provided by each level. The hospital association proposes a stabilization fund to buy the debt portfolios of the hospitals, along with other interventions such as loans with low interest rates, tax reductions, and direct payment from the government to the providers. The decision on how to finance public hospitals while ensuring their financial stability and long-term sustainability is another top priority of the government.

Financial sustainability of the SR will require sustaining and enhancing enforcement of cost-containment policies, particularly for reimbursements for services outside the MBP, especially for medicines. The government requires expanding enforcement and data collection and analysis capabilities to be able to implement the new Pharmaceutical Policy, since high-cost medicines may follow previous trends that emerged in the CR with billions of Colombian pesos spent on reimbursement for expensive medicines not always with a clear therapeutic advantage. Issues that have not been quite resolved and are part of the pending agenda to enhance sustainability require accelerating convergence on pharmaceutical regulation, quality control, and a solid policy to foster the financing of quality generic services. Most important, however, is the continuation of development of an independent health technology assessment institution that may provide guidelines and research to inform health sector decisions.

Improving the Organization of Health Care Services to Foster Health Promotion and Prevention

The existing regulatory framework provides few incentives for strengthening health promotion and prevention efforts and developing effective health care networks. The current administration acknowledged the urgent need to strengthen a comprehensive health care system to foster modern approaches to health services that place greater emphasis on prevention and early diagnosis than on ever more sophisticated treatments (Londoño 2010). Screening, monitoring, and quality of care, for instance, of chronic conditions at the first and second levels of care can vary greatly among providers contracted by different EPSs and municipalities, between the CR and SR, and within each of these regimes. Contracting practices with individual providers as opposed to true health care networks that can provide a comprehensive approach to health care during the entire life cycle weakens the continuum of care delivered by public and private providers and limits implementation of some key public health functions.

In 2011, the government and Congress passed a new law that provided a renewed commitment to enhance primary health care, but first the ongoing debate on the health care model and the role of health plans needs to be resolved. Law 1438 provides a policy framework that seeks to

strengthen health promotion, prevention, and other key primary health care interventions. This new legal framework seeks to foster health promotion and prevention, strengthening the first level of care services within a more integrated approach. The law also establishes principles and guidelines for the organization and strategic interventions of community health care teams to identify household and individual risk factors and foster the demand for key services with a high positive impact on public health (Ministerio de Protección Social 2011). However, discussions on how to implement these interventions and the role of health plans and federal, state, and municipal governments remain to be defined.

Finally, public authorities announced that some regions might need to move out of the health insurance model introduced by Law 100. For various reasons—from public security in areas of conflict to lack of private sector providers—the government decided to explore other options different from the EPSs for the provision of health care services in some areas of the country. The Ministry of Health is systematically exploring the identification of the first areas where other models of provision of services would be tested. Reportedly, options that are considered may require reliance on supply-side financing with exclusively public providers, particularly for some low-density and remote rural areas. Options being considered include contracting nonprofit organizations to manage health care networks in a more integrated fashion to preserve the continuum of care through all levels of care. This may imply moving away from the managed competition model in regions of the country where the Ministry of Health deems the model unviable or not efficient, in order to enhance access to health services and financial protection for poor households (PAHO 2012).

Annex 1 Recurring Public Hospital Imbalances of Revenues and Expenditures

Before 1993, hospitals in Colombia received a fixed amount of money from the central government depending on the number of beds. Additional financial resources came from municipal- and state-level governments, mainly from lotteries and alcohol taxes. The public hospitals before 1993 had problems of efficiency, quality, accessibility, and lack of resources. The typical hospital had no strategic planning, no tools to estimate cost, poor management of human resources, and supply issues. Public hospitals became what were known as State Social Enterprises, and self-financed mainly by selling services to health plans of the CR and SR and to other private insurance and local governments that pay for the uninsured population.

Between 1993 and 1997, the budget of public facilities increased 2.6 times for first level care facilities and by 1.5 for tertiary level care hospitals. The revenues of public hospitals that came from contracts for health care services with health plans quintupled during the first years of the health sector reform. By 1997, most public hospitals were transformed into autonomous public sector corporations managed as firms and known as Public Health Care Providers (*Empresas Sociales del Estado, ESE*). However, large tertiary level hospitals only increased their revenues by 10 percent and secondary level hospitals continued to depend on government subsidies (Sáenz 2001).

Reasons for the financial problems of public hospitals include no experience in selling services in the new market created by Law 100; hospital administrators had no knowledge about contracting or negotiations; and accounting and billing institutional capacities were poor, which impeded efficient and accurate estimates of charges due for most outpatient and inpatient services. Public hospitals had created a schedule of prices for services provided to beneficiaries of car insurance companies. Other important factors include opposition to the changes introduced by Law 100 by labor unions and doctors' associations, lack of transparency regarding the budget, and concerns over corruption and fraud. Strong labor unions negotiated salaries and various benefits and work stability. Public hospitals paid well but frequently irregularly; that is, there were sometimes delays of up to three or four months. Most of the physicians worked only a few hours a day in the public hospitals, and obtained income by working in their private practices and private sector hospitals. In 1998, the Minister of Health and the Colombian Association of Hospitals and Clinics highlighted these issues regarding health care providers in the debate of how to reduce obstacles and improve services of the national health insurance system.

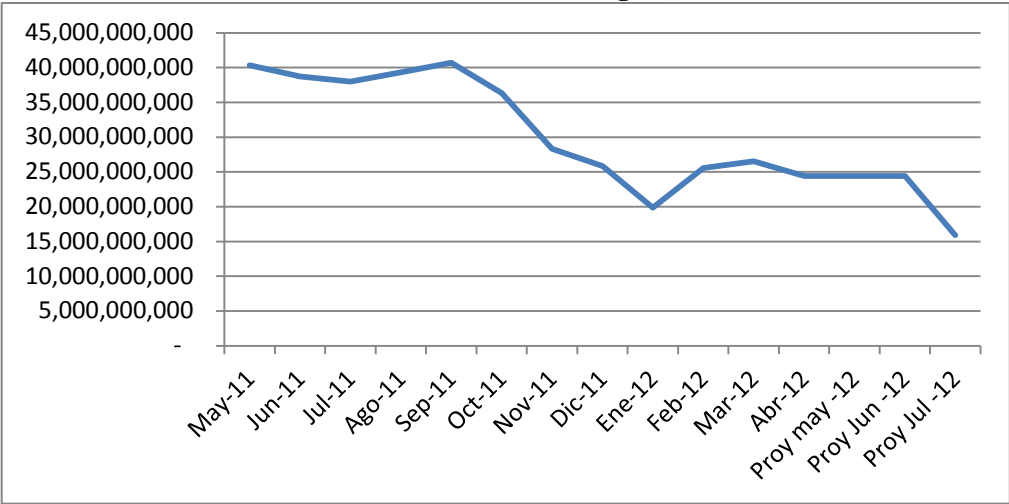
The city of Bogotá presents an interesting example of hospital finances, because there is more information publicly available than in other cities, and it is likely that it may reflect the problems of hospitals in other municipalities, particularly in large urban centers.

The special district of the metropolitan area of Bogotá (Distrito Capital) has about 7.5 million inhabitants. Of the total population living in Bogotá, about 69 percent are enrolled in the contributory regime (half of them are beneficiaries of the main health insurance holder). That means that only about half of the CR beneficiaries are employees in the formal sector which, along with their employer, provides contributions for the CR. About 18 percent of the total population of Bogotá is enrolled in the subsidized regime, and roughly 8.5 percent are not enrolled in any health insurance. In 1993, there were 32 public hospitals in Bogotá, but currently

there are only 22; the other 11 either closed or merged with other public hospitals. The 22 public hospitals are made up of nine first level hospitals, eight second level hospitals, and five third level hospitals. The third level hospitals account for more than 40 percent of the budget and have six times the deficit compared with first level hospitals. A public health network does not exist, and there is a lack of an adequate and clear distribution of roles and responsibilities. Most third level hospitals provide services of first and second level hospitals in order to survive, thereby putting lower level hospitals at risk. For example, the cardiovascular referral hospital (Santa Clara) has 12 lower level services, 57 midlevel services, and 25 higher level services; and Hospital Meisen has 23 lower level services, 44 midlevel services, and 17 higher level services.

In 2009, Bogotá’s public hospitals expected revenues were about COL\$838 billion, but actual revenues reached only COL\$564 billion, a deficit of COL\$273 billion. The sources of revenues for public hospitals include 29 percent from fiscal resources (general taxes), 26 percent from local taxes, 17 percent from FOSYGA (the pooling fund of the CR), and 11 percent from own resources. The hospitals sell services mostly to SR health plans, which by law are obliged to purchase 60 percent of the capitation from the public hospitals. The other source of revenue is financing from the municipal government budget for provision of health services to individuals not enrolled in any health insurance. Payments from Municipal Budgets to public hospitals for services provided to individuals without any health insurance used to be a very important source of revenue. However, as enrolment expanded and the population of individuals not covered by health insurance was reduced, revenues from the Municipal Budget decreased from COL\$40 billion in 2011 to COL\$15 billion in 2012 (figure A.1).

Figure A.1 Public Hospital Revenues from Services Provided to Individuals without Health Insurance in Bogotá, 2011–12



Source: Bogotá Secretary of Health.

The universal coverage paradoxically creates more deficits in the public hospitals, since shifting funds to EPS and private sector providers reduce allocation of funds for individuals not enrolled in any health insurance regime, which constituted an important source of revenue from local governments. The subsidized regime in Bogotá has 1,278,400 people, and the premium capitation is COL\$378 pesos to COL\$763 pesos per year. The EPS has to contract 60 percent

with public hospitals (COL\$484 billion pesos) and uses 8 percent for administration (COL\$38 billion pesos), so the revenues for the public hospitals will be COL\$267 billion, half of what they received in 2009 (table A.1).

Table A.1 Revenues and Deficit of Public Hospitals in Bogotá, 2011
(In billion pesos)

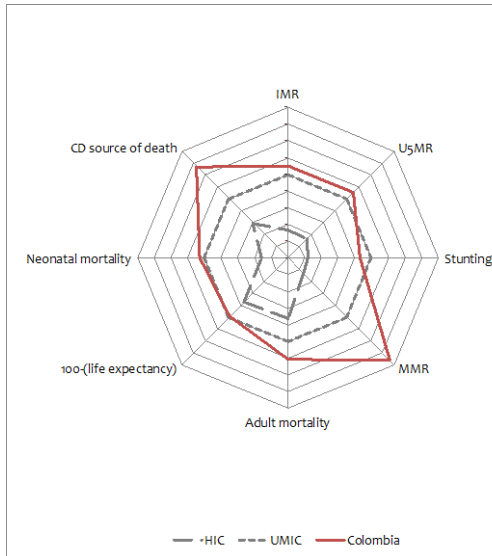
Hospital	Expected Revenues	Expenditures	Revenues	Deficit
I level	378,181	162,195	132,856	29,339
II level	527,334	311,459	133,498	177,961
III level	541,851	303,653	139,884	163,768
TOTAL	1,447,366	777,307	406,238	371,068

Source: Bogotá Secretary of Health.

Human resources management and negotiated benefits are important factors in public hospital bankruptcy. In addition, hospitals need large amounts of money to finance unpaid benefits to senior staff due to public sector human resources management rigidities. Between 1994 and 1997, public hospitals hired 18,600 new employees, and the average salary rose from COL\$223,418 pesos to COL\$546,166 pesos. The largest public hospital (San Juan de Dios) has been closed since 1999. The new administration of the municipal government promised to reopen the hospital in 2012; however, the estimated costs of paying for cash benefits that are owed are a major obstacle without any other source of revenue in sight.

Annex 2 Spider Web

I. Outcomes comparisons: Colombia and Upper Middle Income Countries

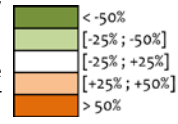


Note on interpretation:

In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

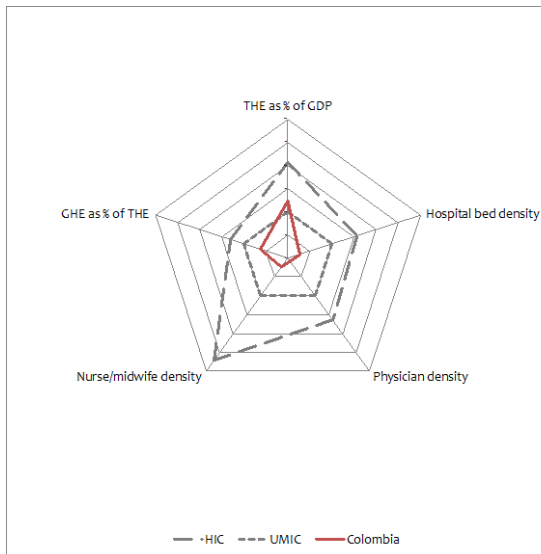
The table below summarizes outcome comparisons with the average upper middle income country (UMIC).



Country Data	Colombia	UMIC	% Diff.
GNI pc (2000 USD)	2465.7	1899.0	29.8%
IMR	18.1	16.5	9.7%
U5MR	21.7	19.6	10.5%
Stunting	12.7	14.8	-13.9%
MMR	92.0	53.2	72.8%
Adult Mortality	193.8	160.6	20.6%
100-Life Expectancy	26.6	27.2	-2.2%
Neonatal Mortality	12.0	11.4	5.3%
CD mortality	34.0	22.0	54.5%

IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

II. Inputs comparisons Colombia and Upper Middle Income Countries

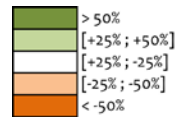


Note on interpretation:

This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

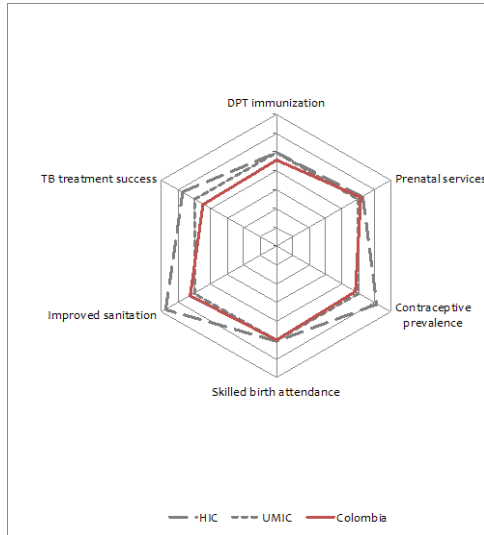
The table below summarizes inputs comparisons with the average upper middle income country (UMIC).



Country Data	Colombia	UMIC	% Diff.
GNI pc (2000 USD)	2465.7	1899.0	29.8%
THE %GDP	7.6	6.1	24.2%
Hosp. bed density	1.0	3.7	-72.7%
Phys. density	0.1	1.7	-91.3%
Nur./midwife dens.	0.6	2.6	-76.4%
GHE %THE	33.8	54.3	-37.8%

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

III. Coverage comparisons Colombia and Upper Middle Income Countries

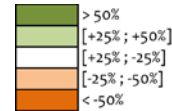


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average upper income country value.

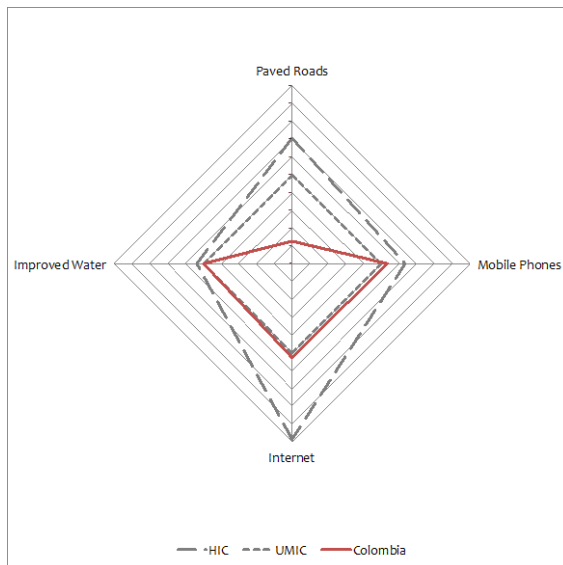
The table below summarizes coverage comparisons with the average upper middle income country (UMIC).



Country Data	Colombia	UMIC	% Diff.
GNI pc (2000 USD)	2465.7	1899.0	29.8%
DPT	88.0	95.8	-8.1%
Prenatal	97.0	93.8	3.4%
Contraceptive	78.2	80.5	-2.9%
Skilled birth	97.7	98.0	-0.3%
Sanitation	77.0	73.0	5.5%
TB success	77.0	86.0	-10.5%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

IV. Infrastructure comparisons Colombia and Upper Middle Income Countries

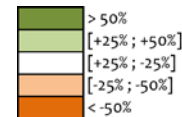


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

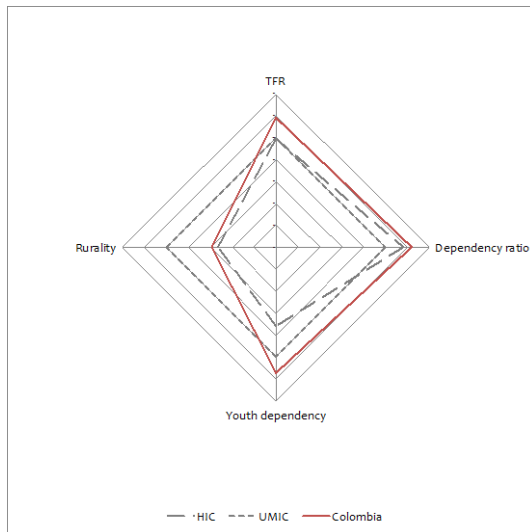
The table below summarizes infrastructure comparisons with the average upper middle income country (UMIC).



Country Data	Colombia	UMIC	% Diff.
GNI pc (2000 USD)	2465.7	1899.0	29.8%
Paved roads	14.4	57.6	-75.0%
Mobile phones	98.5	92.3	6.6%
Internet	40.4	38.3	5.4%
Water	92.0	92.6	-0.6%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

V. Demography comparisons Colombia and Upper Middle Income Countries

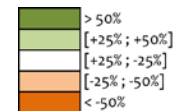


Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

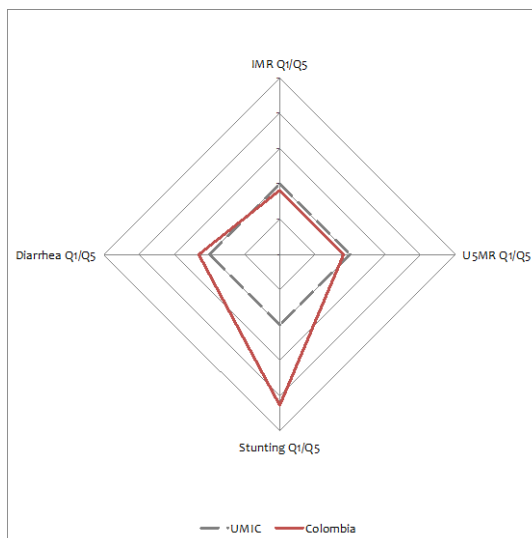
The table below summarizes demographic indicators comparisons with the average upper middle income country (UMIC).



Country Data	Colombia	UMIC	% Diff.
GNI pc (2000 USD)	2465.7	1899.0	29.8%
TFR	2.1	1.8	18.6%
Dependency (Total)	52.4	42.2	24.0%
Youth share	83.6	73.0	14.5%
Rural pop.	24.9	42.6	-41.5%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

VI. Inequality comparisons Colombia and Upper Middle Income Countries

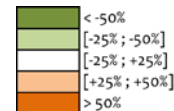


Note on interpretation:

In this plot 'higher' is 'inequal' and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The values on the radar plot have been standardized with respect to the average upper middle income country value. Data are not available for high income countries (HIC).

The table below summarizes inequality indicators comparisons with the average upper middle income country (UMIC).



Country Data	Colombia	UMIC	% Diff.
GNI pc (2000 USD)	2465.7	1899.0	29.8%
IMR Q1/Q5	2.2	2.4	-8.3%
U5MR Q1/Q5	2.4	2.7	-9.6%
Stunting Q1/Q5	7.0	3.3	113.2%
ARI Q1/Q5	NA	1.4	.
Diarrhea Q1/Q5	2.0	1.7	15.0%

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data (latest data available) are taken from HNPstats (<http://data.worldbank.org/data-catalog/HNPquintile>).

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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