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Report No: ICR00326

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IBRD 9072-CO; GCFF TF0B2826)

ON A LOAN IN THE AMOUNT OF

US$150 MILLION

AND A GRANT FROM THE GLOBAL CONCESSIONAL FINANCING FACILITY IN THE AMOUNT OF

US$37.60 MILLION

TO THE

REPUBLIC OF COLOMBIA

FOR THE

IMPROVING QUALITY OF HEALTH CARE SERVICES AND EFFICIENCY IN COLOMBIA

PROGRAM-FOR-RESULTS

June 23, 2025

Health, Nutrition & Population
Latin America And Caribbean

CURRENCY EQUIVALENTS

(Exchange Rate Effective January 10, 2025)

Currency Unit =	Colombian Pesos
COP 4,340.28 =	US$1
US$0.00023 =	COP 1
US$0.77 =	SDR 1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Carlos Felipe Jaramillo
Country Director:	Mark Roland Thomas
Regional Director:	Jaime Saavedra
Practice Manager:	Tania Dmytraczenko
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ABBREVIATIONS AND ACRONYMS

ADRES	Administrator of the Resources of the General System of Social Security in Health (*Administradora de los Recursos del Sistema General de Seguridad Social en Salud*)
AP	Action Program
BDUA	Unified Database of Affiliation (*Base de Datos Única de Afiliados*)
CAC	High-Cost Account *(Cuenta de Alto Costo)*
CGR	Comptroller General of the Republic *(Contraloría General de la República)*
COP	Colombian Pesos
CPF	Country Partnership Framework
DLI	Disbursement-Linked Indicator
DNP	National Planning Department *(Departamento Nacional de Planeación)*
EFO	Externally Financed Outputs
EPS	Health Insurance Company *(Entidad Promotora de Salud)*
ESE	State Social Enterprises *(Empresa Social del Estado)*
ESSA	Environmental and Social Systems Assessment
FA	Financing Agreement
FM	Financial Management
GBV	Gender-based violence
GCFF	Global Concessional Financing Facility
GDP	Gross Domestic Product
GoC	Government of Colombia
GRS	Grievance Redress Service
HCW	Health Care Waste
ICR	Implementation Completion and Results Report
IDB	Inter-American Development Bank
IDEAM	The national environmental authority *(Instituto de Hidrología, Meteorología y Estudios Ambientales)*
INVIMA	National Institute for Food and Drug Surveillance (*Instituto Nacional de Vigilancia de Medicamentos y Alimentos*)
IPS	Health Care Provider *(Institución Prestadora de Servicios de Salud)*
IR	Intermediate Result
IRI	Intermediate Results Indicator
ISR	Implementation Status and Results Report
IVC	Inspection, Surveillance and Control *(Inspección, Vigilancia y Control)*
L-2	Level 2 (Restructuring)
MADS	Ministry of Environment and Sustainable Development *(Ministerio de Ambiente y Desarrollo Sostenible)*
MSPS	Ministry of Health and Social Protection (*Ministerio de Salud y Protección Social)*
NARP	Black Afro-Colombian, Raizal and Palenquero *(Negro, Afrocolombiano, Raizal y Palenquero)*
NCIS	National Cancer Information System
NCD	Non-communicable disease
OECD	Organisation for Economic Co-operation and Development
OPS	Pan American Health Organization *(Organización Panamericana de la Salud)*
PAP	Program Action Plan
PBS	Health Benefits Package *(Plan de Beneficios en Salud)*

PDO	Program Development Objective
PDOI	Program Development Objective Indicator
PEP	Special Permit of Permanence *(Permiso Especial de Permanencia)*
PforR	Program-for-Results
PHC	Primary Health Care
PLR	Performance and Learning Review
PND	National Development Plan *(Plan Nacional de Desarrollo)*
POS	Mandatory Health Insurance (*Plan Obligatorio de Salud*)
RA	Results Area
RESPEL	Registry of Generators of Waste or Hazardous Waste (*Registro de Generadores de* Residuos o Desechos Peligrosos)
RF	Results Framework
SGSSS	General System of Social Security in Health *(Sistema General de Seguridad Social en Salud)*
SENA	National Learning Service *(Servicio Nacional de Aprendizaje)*
SISMED	Drug Price Information System *(Sistema de Información de Precios de Medicamentos)*
SISPRO	Social Protection Integrated Information System *(Sistema Integrado de Información de la Protección Social)*
SOGC	Mandatory Guarantee System for Quality of Care *(Sistema Obligatorio de Garantia de* la Calidad)
SSA	Deputy Directorate of Environmental Health *(Subdirección de Salud Ambiental)*
SUISA	Single Environmental Health Information System (*Sistema Unificado de Información en Salud Ambiental)*
TA	Technical Assistance
ToC	Theory of Change
TTL	Team Task Leader
UPC	Capitation Payment Unit (*Unidad de Pago por Capitación*)
WB	World Bank
WEEE	Waste from Electrical and Electronic Equipment

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DATA SHEET

BASIC DATA

Product Information

Operation ID	Operation Name
P169866	Improving Quality of Health Care Services and Efficiency in Colombia
Product	**Operation Short Name**
Program-for-Results Financing (PforR)	Improving Health Quality and Efficieny
Operation Status	**Approval Fiscal Year**
Closed	2020
IPF Component?	
No	
Original EA Category	

CLIENTS

Borrower/Recipient	Implementing Agency
Ministry of Finance, Republic of Colombia	Ministry of Health and Social Protection, Republic of Colombia

DEVELOPMENT OBJECTIVE

Original Development Objective (Approved as part of Approval Package on 19-Mar-2020)

The Development Objective of the Program is to support improvements in the quality of health care services and in the efficiency of the health system

FINANCING

Financing Source	Original Amount (US$)	Revised Amount (US$)	Actual Disbursed (US$)
World Bank Financing	150,000,000.00	150,000,000.00	123,438,000.00
IBRD-90720	150,000,000.00	150,000,000.00	123,438,000.00
World Bank Administered Financing	37,600,000.00	37,600,000.00	30,935,000.00
TF-B2826	37,600,000.00	37,600,000.00	30,935,000.00
Non-World Bank Financing	1,795,400,000.00	1,795,400,000.00	1,795,400,000.00
Borrower/Recipient	1,795,400,000.00	1,795,400,000.00	1,795,400,000.00
Total	**1,983,000,000.00**	**1,983,000,000.00**	**1,949,773,000.00**

RESTRUCTURING AND/OR ADDITIONAL FINANCING

Date(s)	Type	Amount Disbursed (US$M)	Key Revisions
28-Mar-2023	Portal	142.65	• Disbursement Estimates • Loan Closing Date Extension
26-Jun-2024	Portal	154.37	• Disbursement Estimates • Loan Closing Date Extension • Implementation Schedule
20-Dec-2024	Portal	154.37	• Results • Legal Covenants • Reallocations

KEY DATES

Key Events	Planned Date	Actual Date
Concept Review	14-May-2019	14-May-2019
Decision Review	07-Nov-2019	08-Nov-2019
Authorize Negotiations	21-Jan-2020	14-Jan-2020
Approval	19-Mar-2020	19-Mar-2020
Signing	30-Nov-2020	30-Nov-2020
Effectiveness	01-Dec-2020	01-Dec-2020
Change Financing Product Sequence.01	--	11-Apr-2019

Restructuring Sequence.01	Not Applicable	28-Mar-2023
Restructuring Sequence.02	Not Applicable	26-Jun-2024
Restructuring Sequence.03	Not Applicable	20-Dec-2024
Mid-Term Review No. 01	08-Apr-2022	--
Operation Closing/Cancellation	31-Dec-2024	31-Dec-2024
ICR/NCO	30-Jun-2025	--

RATINGS SUMMARY

Outcome	Bank Performance	M&E Quality
Moderately Satisfactory	Satisfactory	Substantial

ISR RATINGS

No.	Date ISR Archived	DO Rating	IP Rating	Actual Disbursements (US$M)
01	23-Jun-2020	Satisfactory	Satisfactory	0.00
02	06-Jan-2021	Satisfactory	Satisfactory	99.03
03	21-Jul-2021	Satisfactory	Satisfactory	99.03
04	24-Jan-2022	Satisfactory	Satisfactory	126.45
05	30-Jun-2022	Satisfactory	Satisfactory	126.45
06	17-Dec-2022	Satisfactory	Satisfactory	142.65
07	07-Jun-2023	Moderately Satisfactory	Satisfactory	142.65
08	11-Dec-2023	Moderately Satisfactory	Satisfactory	142.65
09	19-Jun-2024	Moderately Satisfactory	Moderately Satisfactory	154.37
10	23-Dec-2024	Moderately Satisfactory	Moderately Satisfactory	154.37

SECTORS AND THEMES

Sectors

Major Sector	Sector	%	Adaptation Co-benefits (%)	Mitigation Co-benefits (%)
FY17 - Health	FY17 - Health	88	6	1
	FY17 - Health Facilities and Construction	12	40	10

Themes

Major Theme	Theme (Level 2)	Theme (Level 3)	%
FY17 - Environment and Natural Resource Management	FY17 - Climate change	FY17 - Adaptation	10
		FY17 - Mitigation	3
FY17 - Human Development and Gender	FY17 - Health Systems and Policies	FY17 - Health Finance	50
		FY17 - Health Service Delivery	75
		FY17 - Health System Strengthening	38

ADM STAFF

Role	At Approval	At ICR
Practice Manager	Michele Gragnolati	Tania Dmytraczenko
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Co-Team Leader(s)	Jeremy Henri Maurice Veillard	Vanina Camporeale
ICR Main Contributor	Maria Cecilia Zanetta	

I. PROGRAM CONTEXT AND DEVELOPMENT OBJECTIVES

A. CONTEXT AT APPRAISAL

Country Context

1. **At the time of project preparation (2019), Colombia's economic growth was gradually recovering from the significant external shocks experienced during the 2014-2015 period.** With the support of sound fiscal and monetary policies, the country's Gross Domestic Product (GDP) growth had gradually increased from 1.4 percent in 2017 before accelerating gradually to 2.6 percent in 2018. However, while the authorities remain committed to sound fiscal and monetary policies, the tax reforms approved over the past years have not yet generated much needed structural increases in revenues. Thus, in order to comply with a fiscal rule mandating a reduction of 1.5 percentage points of GDP in the central government fiscal deficit between 2018 and 2022, drastic spending cuts were already being implemented, and more were expected in 2020.

2. **The process of internal peace consolidation and the large migration inflow from Venezuela added significant additional fiscal pressures to the already tight fiscal context.** Post-conflict spending commitments (i.e., an estimated 0.7 percent of the GDP per year) and spending related to the migration flows from Venezuela were adding pressure on Colombia's tight fiscal space. In 2019, there were roughly 1.63 million Venezuelans in Colombia, many of whom were not only income poor but also had acute health care needs as a result of the collapse of the Venezuelan health system. In order to provide access to services to eligible migrants at a level similar to that provided to the local population, additional fiscal consolidation measures over the 2020-2022 period were needed, including targeted expenditure containment and rationalization as well as efficiency-enhancing measures.

Sectoral and Institutional Context

3. **The Colombian General System of Social Security in Health (*Sistema General de Seguridad Social en Salud*, SGSSS) provides almost universal insurance coverage and a significant level of financial protection to its beneficiaries.** The SGSSS is structured around two main insurance schemes or regimens: (i) a contributive regime for salaried, pensioned, and independent workers; and (ii) a subsidized scheme for the low income, vulnerable, displaced, and incarcerated populations. Regarded as one of the country's major social achievements of the last decades, it had resulted in a drastic increase in health insurance coverage, including among the poor, from 23.5 percent in 1993 (the year of approval of the supporting health reform legislation) to around 94-96 percent from 2010 onward. Nevertheless, insurance coverage remained low among registered migrants and indigenous groups in frontier areas.

4. **The SGSSS functions through a strategy of managed competition aimed at promoting efficiency and quality**. At first tier, health insurance companies (*Entidades Promotoras de Salud*, EPSs) compete for consumers in terms of the quality of the services offered, as citizens are free to choose among EPSs. EPSs derive their revenues from a capitation payment (*Unidad de Pago por Capitación*, UPC) multiplied by the number of insured persons. The capitation payment is determined by the GoC and adjusted on an annual basis. At the second tier, health care providers (*Instituciones Prestadoras de Servicios de Salud*, IPSs) compete to be contracted by the EPSs on the basis of a price-quality combination.

5. **The Colombian legislation assigns to the Ministry of Health and Social Protection (*Ministerio de Salud y Protección Social,* MSPS) the role of steward of the health sector.** Specific roles and functions include the formulation and evaluation of policies, plans, programs, and projects related to patient protection, promotion and prevention, health insurance and professional risks, provision of services and Primary Health Care (PHC), financing and information systems as well as the formulation, adoption and evaluation of policies related to pharmaceuticals, medical devices and supplies and biomedical technology. The MSPS also has the responsibility of developing and

implementing mechanisms and strategies aimed at optimizing the use of these inputs. The planning function for health care services is the responsibility of departments and municipalities (*Entidades Territori*ales), which are also responsible for supervising public hospital service delivery. As mentioned above, the insurance function is the responsibility of the EPSs and the delivery of care of the IPSs and departments.

6. **While some health outcomes had shown important progress, the country was experiencing a rapid increase in the prevalence of non-communicable diseases (NCDs) as a result of ongoing demographic and epidemiological transitions.** While chronic malnutrition, adolescent pregnancy, and vaccination coverage, among others, had shown substantial improvements, NCDs had become the main cause of death and disability. As the treatments of chronic diseases are more complex and expensive, the increased burden of NCDs has contributed to the rapid growth of total health spending. Moreover, much of the focus of the Colombian health policy agenda since the health reform of 1993 had been directed towards the expansion of insurance and service provision coverage, boosting the provision of curative care to the detriment of health risk management, health promotion, and primary and secondary disease prevention. As a result, quality-related indicators, such as those associated with early cancer detection, hospital readmission rates, avoidable hospitalizations, and pregnant women receiving adequate prenatal care remained below optimum levels and/or were lower than the average in the Latin America and the Caribbean region.

7. **The need to strengthen the quality of health services was confirmed by an external assessment of Colombia's quality of health care in both the public and private sector financed by the World Bank (WB) and the International Finance Corporation (IFC).**[1] The main recommendations underscored the need to: (i) strengthen capacity for continuous quality improvement in the health sector; (ii) strengthen the quality ecosystem in the sector including the policy and regulatory regime; (iii) improve the rigor and use of information on quality to stimulate patient choice and peer learning for IPSs; (iv) develop and implement an integrated care model focused on high-performing PHC to support the management of individuals with complex, chronic health care needs; and (v) improve accountability and contracting mechanisms to incent for quality. Similarly, an in-depth assessment of the performance of Colombia's PHC system based on the PHC Performance Initiative framework showed performance gaps in quality of care and effective coverage. Findings showed that even though Colombia had achieved high levels of access to PHC, results are not commensurate in effective coverage, pointing to two bottlenecks to system performance: the quality of care delivered and the equitable distribution of this care across the population.[2]

8. **Other challenges facing the efficiency and financial sustainability of Colombia's health care system included the need to strengthen pharmaceutical policies and control the growth in judicial health-related claims.** Although the cost of medicines represented, on average, approximately 21 percent of the SGSSS total health spending between 2007 and 2017, results in terms of access to medicines had been mixed. Moreover, the reimbursement, through judicial claims, of high-cost inputs (mostly medications), services and procedures not included in the benefit plan (*Plan Obligatorio de Salud,* POS) had escalated in the past 10 years, from COP 600 billion in 2007 to COP 2.5 trillion in 2016 (i.e., around 10 percent of total expenditure of the MSPS). In addition, the provision of health care services to Venezuelan migrants had put additional pressure on the financing of the health system as well as the quality of services in areas characterized by pre-existing deficits in service provision, such as the department of La Guajira.

[1] World Bank and IFC (2019), *External Assessment of Quality of Care in the Health Sector in Colombia,* Report No. AUS853, July 17, 2019, World Bank Group: Washington, D.C.
[https://documents1.worldbank.org/curated/en/719321564123515864/pdf/External-Assessment-of-Quality-of-Care-in-the-Health-Sector-in-Colombia.pdf]

[2] World Bank (2020), *Primary Health Care Vital Signs Profile Assessment for Colombia*, World Bank Group, Washington, D.C.
[http://hdl.handle.net/10986/35021]

Finally, given its tropical geographic location, biodiversity and topography, Colombia is particularly vulnerable to climate change, with significant impacts on the health sector.

Theory of Change (ToC) (Results Chain)

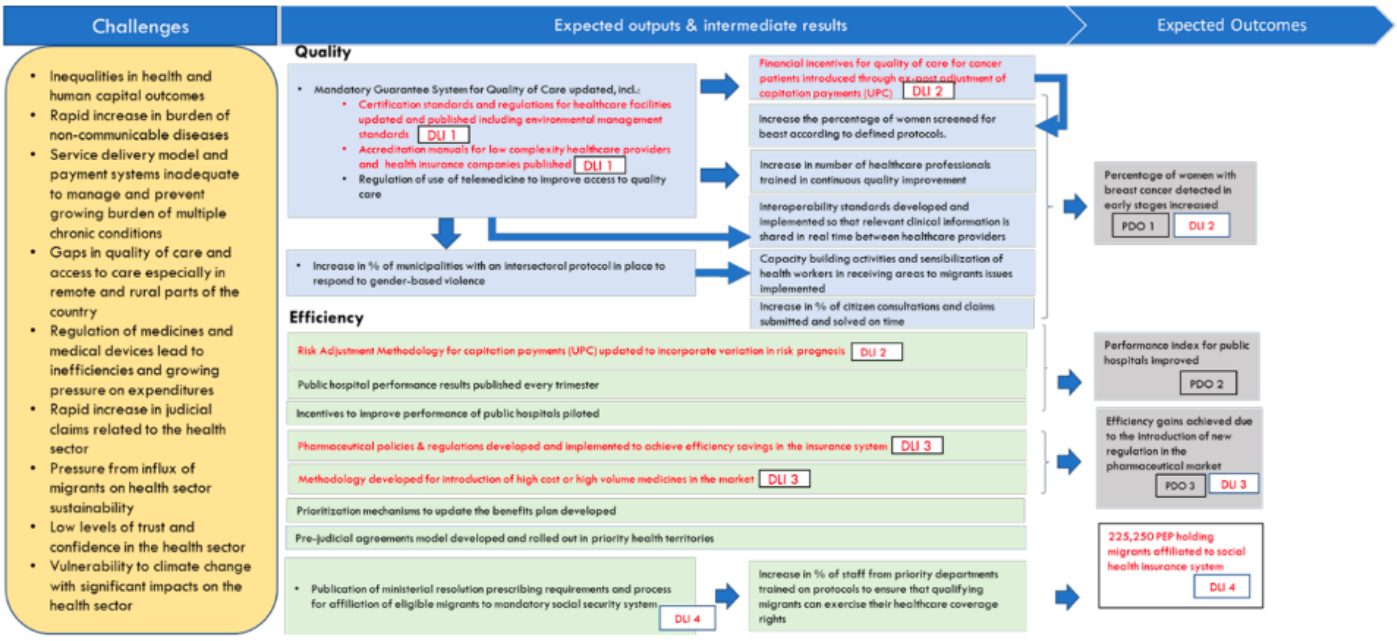
9. **This Program supported improvements in quality and efficiency in the Colombian health system through a Program-for-Results (PforR) instrument.** It was structured under two Results Areas (RAs) aimed at increasing the quality of health services and the efficiency of the health system. Under the PforR instrument, financial incentives were linked to the achievement of specific results (Disbursement-Linked Indicators, DLIs), including: (i) the implementation of policy actions aimed at improving quality of services and overall efficiency; and (ii) quantifiable outcomes reflecting the impact of such policy actions. As an illustration, under the RA focusing on quality, the PforR provided support to the enactment of legislation introducing financial incentives to promote the quality of health services for cancer patients (i.e., policy action) as well as the resulting improvements in cancer care (i.e., measurable impact on quality of cancer care, including early detection). Similarly, under the RA focusing on efficiency, the PforR provided support for the passage of regulation of pharmaceutical inputs (i.e., policy action) as well as the resulting cost savings (i.e., measurable impact in terms of efficiency).

10. **A detailed Results Chain was included in the Program Appraisal Document (PAD).**[3] It summarized: (i) the main challenges facing Colombia's health system; (ii) the expected outputs and Intermediate Results (IRs) under the two RAs; and (iii) the main expected outcomes. In addition, those outputs, IRs, and outcomes that were directly linked to the financial incentives provided under the PforR were highlighted in red. As an illustration, the policy actions and corresponding measurable impact for the two examples described above are shown under DLIs 2 and 3, respectively.

11. **There were several implicit assumptions underlying the Program's ToC**, including: (i) adequate institutional capacity to ensure the Program's successful implementation; (ii) continuous political support and macroeconomic stability; and (iii) no drastic changes in external conditions due to natural disasters or health emergencies.

[3] World Bank (2020), *Colombia - Improving Quality of Health Care Services and Efficiency in Colombia Program,* Washington, D.C.: World Bank Group. (See p. 24.)
[http://documents.worldbank.org/curated/en/842881584928823176/Colombia-Improving-Quality-of-Health-Care-Services-and-Efficiency-in-Colombia-Program]

Figure 1. ToC



Rationale for PforR Support, and Program Scope and Boundaries

12. **This Program was fully aligned with the strategic priorities of both the Government of Colombia (GoC) and the WB.** Specifically, the Program Development Objectives (PDOs) were directly aligned with the health sector goals of the National Development Plan *(Plan Nacional de Desarrollo,* PND) 2018-2022 (i.e., "Health for all with quality and efficiency, sustainable by all"). Equally important, by supporting the improvement in the quality of health care services and efficiency of spending in the health sector, it contributed to Pillar 2, Objective 3 of the WBG's 2016-2021 Country Partnership Framework (CPF) for Colombia (i.e., "to enhance social inclusion and mobility through improved service delivery").[4] In addition, by assisting Colombia to accelerate progress towards the achievement of Universal Health Coverage, the Program was also in line with the WB's twin goals of eliminating extreme poverty and boosting shared prosperity. Finally, it was also closely aligned with the United Nations' Sustainable Development Goals that stress the importance of achieving universal health care coverage and financial protection.

13. **The PforR instrument was deemed particularly suitable given that the GoC had a coherent, clearly defined health sector program in place.** It also provided an opportunity to support large systemic changes with relatively small external based on the achievement on tangible, transparent, and verifiable results. Other considerations included: (i) Colombia's sound institutions and procedures could support the implementation of a PforR; (ii) the use of the PforR instrument would help ensure the continuous focus on key sector priorities, minimizing the impact of political uncertainties; (iii) the PforR instrument could also lead to improvements, as necessary, in the implementation of Governments' own technical, fiduciary and safeguard systems; and (iv) the PforR instrument could help maximize the value added of external financing by ensuring complementarity with an operation financed by the Inter-American

[4] Colombia - Country partnership framework for the period FY16-21 (English). Washington, D.C.: World Bank Group. http://documents.worldbank.org/curated/en/940691468184792587

Development Bank (IDB), also providing support for the GoC's health sector program.[5]

14. **The boundaries defined for the PforR within the Government's 2018-2022 PND are presented in Table 1 below.** The PforR supported specific results under Objectives I, III, V and VI of the GoC's health program, and Objective II of the Pact for Women, all of which were related to improving quality and efficiency in the SGSSS. The PforR focused on its assistance in the health sector stewardship and managerial functions of the MSPS and, as such, supported the development of policies and regulations required to achieve the Program's expected results during its three-year anticipated implementation period (2020-2022). It was estimated that this PforR, financed by a US$150 million WB loan and a US$37.6 million grant from the Global Concessional Financing Facility (GCFF), would finance roughly 10 percent of the PND's budgetary allocation to the subprogram *Insurance and Management of the SGSSS*, which had a cost of roughly US$2 billion dollars over the 2020-2022 period.

Table 1. Scope of the Government's program and PforR's Program

PND 2018-2022	PforR	
	Area of Support	Result Area
Health Pact: Health for all with quality and efficiency, sustainable by all		
I. Stewardship and governance	Yes	Quality and Efficiency
II. Public Health	No	
III. Quality	Yes	Quality and Efficiency
IV. Infrastructure and resources	No	
V. Human Resources for Health	Yes	Quality
VI. Efficiency and financial Sustainability	Yes	Efficiency
Equity Pact for Women: Women's rights to live without violence		
Cross Cutting Program	Objective II. Institutional strengthening to protect female victims of violence	Quality

PDOs, Key Expected Outcomes and Outcome Indicators

15. **The PDOs were to support improvements in: (i) the quality of healthcare services; and (ii) the efficiency of the health system.**[6] Three PDO Indicators (PDOIs) were adopted to assess PDO achievement (see Table 2). In addition, 13 Intermediate Results Indicators (IRIs) measured other important intermediate steps in support of PDO achievement (see Annex 1.a for the complete Program's Results Framework (RF)).

[5] The IDB-financed operation was also results-based, with a focus on efficiency and the financial sustainability of the SGSSS. It had three components: (i) improve the management and control of expenses not financed by the UPC, such as those generated by new technologies that had not been incorporated into the benefit plan; (ii) support the implementation of the Integral Territorial Action Model, which sought to strengthen local authorities and engage the community in the joint development of health plans to improve the health of the population; and (iii) complementary to the World Bank's PforR, this component also supported the affiliation of regularly registered Venezuelan migrants to the SGSSS.
[6] The definition included in the PAD and Financial Agreement (FA) was: "The objectives of the Program are to support improvements in the quality of healthcare services and in the efficiency of the health system."

Table 2. Program Outcome Indicators

PDO 1 - Quality	Baseline	End-Target
PDOI 1. Percentage of women with breast cancer detected in early stages, up to stage IIA, at the time of diagnosis.	55.7%	69%
PDO 2 - Efficiency	**Baseline**	**End-Target**
PDOI 2. Performance index (PI) for public hospitals (i.e., composite performance index of 24 performance indicators).[7]	61%	70%
PDOI 3. Efficiency gains achieved over the period 2020-2022 with the introduction of new regulations in the pharmaceutical market.	0	COP 800 billion

Program RAs and DLIs

16. **The PforR was structured around two RAs, which focused on:**

- *RA 1 To improve the quality of health care services (US$93.8 million):* This RA aimed to improve the quality of health care services provided by the SGSSS. It provided support to a wide range of interventions to be implemented by the MSPS, including, among others: the introduction of financial incentives for quality of care for cancer patients and reporting through *ex-post* adjustment of the UPC payment to EPSs; the updating of accreditation and certification standards of IPSs, low-complexity hospitals and EPSs; capacity building of health workers, including sensibilization toward migrants' issues and gender-based violence; and support for the further expansion of new technologies (e.g., telemedicine, system interoperability) to support health care provision.

- *RA 2 To improve efficiency in the health system (US$93.8 million):* This RA provided support for the implementation of targeted interventions aimed at improving the efficiency in the delivery of health services within the SGSSS, including measures aimed at ensuring efficiency in the delivery of services to migrants. These interventions included, among others: the approval and implementation of a new methodology to regulate medicine prices; the development of a prioritization methodology for the benefit plan; the technical review of the risk-adjustment methodology; the introduction of pay-for-performance pilot in public hospitals; activities to promote the affiliation of migrants holding a Special Permit of Permanence *(Permiso Especial de Permanencia*, PEP) to the SGSSS; and the piloting of pre-judicialization mechanisms.

17. **The disbursement of funds under this PforR was based on four DLIs.** In turn, each DLI included several sub-indicators (milestones), with predetermined disbursements linked to their achievement (see Table 3).

Table 3. DLIs

DLIs	Disbursements US$ million (% of total proceeds)	Milestones and Associated Disbursement Amount
Results Area 1 – Quality		
DLI 1 Updated and new regulations defining the processes and standards for the certification (*habilitación*) of IPSs and for the accreditation of EPSs.	46.9 (25%)	**DLI 1.1** Updated registration and licensing standards for IPSs (US$11.72 million). **DLI 1.2** New accreditation process for EPSs, including quality standards and quality-assurance processes (US$17.59 million).

[7] Introduced in 2018, the PI is a compound indicator that includes 24 management indicators for public hospitals: (i) seven sub-indicators focusing on public health; (ii) eight sub-indicators focusing on quality of care; and (iii) nine sub-indicators focusing on financial performance and indebtedness.

		DLI 1.3 Regulation defining quality standards and simplified processes for the accreditation of low-complexity hospitals (US$17.59 million).
DLI 2 Incentives introduced in the payment system to achieve higher quality of care and efficiency.[8]	46.9 (25%)	**DLI 2.1** Design and implementation of an *ex-post* financial incentive for the EPSs to promote the earlier detection of prioritized cancers, including breast cancer (US$15.63 million) **DLI 2.2** Technical review of risk adjustment methodology of the UPC (US$15.63 million) **DLI 2.3 (80 percent of PDOI 1)** Eighty-percent achievement of PND targets for early detection of breast cancer for 2022 (US$15.64 million)
Results Area 2 –Efficiency		
DLI 3 Efficiency gains in pharmaceutical expenditure as a consequence of pharmaceutical market regulatory policies.	46.9 (25%)	**DLI 3.1** Public consultation of the methodology for the regulation of prices of medicines (US$11.72 million). **DLI 3.2** Application of the existing price regulation methodology to at least 50 relevant markets (US$11.73 million). **DLI 3.3** New methodology to control the introduction of high-cost drugs in the market (US$11.73 million). **DLI 3.4 (PDOI 3)** Efficiency gains resulting from the difference between the regulated price and the original price of at least COP 800 billion (US$11.72 million).
DLI 4 Number of eligible migrants affiliated to the SGSSS.	46.9 (25%)	**DLI 4-1** Revised conditions for SGSSS enrollment for PEP-holding Venezuelan migrants (US$11.72 million). **DLI 4.2-4** Achievement of targets for SGSSS enrollment of eligible migrants (US$35.18 million).

B. SIGNIFICANT CHANGES DURING IMPLEMENTATION

Revised PDOs Outcome Targets, RAs, and DLIs

18. **The Program underwent three Level 2 (L-2) restructurings.** While the first two only extended the closing date and updated the disbursement estimates, the third one introduced modification to one PDOI targets and DLIs. The specific modifications introduced under each restructuring can be summarized as follows:

- *First Restructuring.* A Level 2 (L-2) restructuring was approved on March 28, 2023, to extend the closing date of both the IBRD loan and the GCFF grant by fifteen months, from March 31, 2023, to June 30, 2024. This extension was intended to provide sufficient time to achieve critical indicators and agree with the new administration on potential changes that could arise with a newly proposed health reform. The disbursement estimates were also updated accordingly.

- *Second Restructuring.* A L-2 restructuring was approved on June 26, 2024, to extend the closing date of both the IBRD loan and the GCFF grant by an additional six months, from June 30, 2024, to December 31, 2024, resulting in

[8] DLI 2 is included under PDO 1 to follow the narrative presented in the PAD. It should be noted, however, that its achievement was also expected to have an impact on efficiency, as shown in the TOC.

a cumulative extension of 21 months. The extension was intended to provide sufficient time to revise and adjust the RF under a subsequent restructuring. The disbursement estimates and implementation schedule were also updated accordingly.

- *Third Restructuring.* A L-2 restructuring was approved on December 20, 2024, to align the Program with: (i) changes in the government's strategic orientation for the health sector; (ii) the disruption of preventive health services for women at risk of breast cancer during the COVID-19 pandemic; and (iii) the need to adjust the baseline and operational definition of PDOI 1. The specific modifications included: (i) changes to PDOI 1 (i.e., baseline and target) and DLI 2.3 (i.e., target) to correct an overestimated baseline as well as reflect the disruption of preventative health services for women at risk of breast cancer during the COVID-19 pandemic; and (ii) reallocation of funding across DLIs as well as changes to one DLI milestone (i.e., DLI 1.2), the inclusion of a new milestone (i.e., DLI 2.4) and the elimination of one IRI (i.e., IRI 1) to ensure alignment with new government priorities (Table 4). Minor adjustments also were introduced to the Financing Agreement (FA) and a legal covenant to reflect these changes. Albeit with significant delays due to lengthy approval processes on the side of the client, this restructuring constituted the second stage of the previous restructuring.

Table 4. Modifications Introduced to the RF and DLIs under the Third Restructuring

RF Indicators	Rationale for Change	Baseline %	Target %
PDOI 1. Percentage of women with breast cancer detected in early stages, up to stage IIA, at the time of diagnosis.	*Baseline:* 2018 data (55.7 percent) replaced by 2019 data (49.86 percent). *Target:* Revised downwards from 69 percent to 55 percent to account for lower baseline and the impact of the COVID-19 pandemic.	*2018:* 55.7 *2019:* 49.86	*Original:* 69 *Revised:* 55
IRI 1 Ministerial Decree Mandatory Guarantee System for Quality of Care (*Sistema Obligatorio de Garantía de la Calidad*, SOGC)	Although already prepared, dropped due to shifting government priorities, with the new focus being on defining enhanced quality standards for PHC providers (revised DLI 1.2).	N.A.	N.A.
DLIs	**Rationale for Change**	**Disbursement Amount** (US$ million) **Original**	**Revised**
DLI 1.2 (Original) Administrative act defining processes and standards for the accreditation of EPSs that include quality and environmental management standards, published in the Official Journal.	Revised, as no longer relevant under the new MSPS' strategic vision, in which the role of EPSs as intermediaries in the administration of public resources would be drastically reduced.	17.59	--
DLI 1.2 (Revised) The MSPS regulation defining quality standards for PHC facilities that promote environmental sustainability, has been issued and published in the Official Journal.	Revised to reflect greater priority given to PHC in the provision of services. It follows the same principle and intent of the original DLI 1.2, aiming at enhanced quality standards for health care provision, ensuring adequate diversity and inclusion provisions, and environmental management standards.	--	17.59
DLI 2.3 (Revised) At time of diagnosis, 66.3 percent of women with breast	Revised to align with revised PDOI 1, as follows: At time of diagnosis, 51.5 percent of women with breast cancer were detected at stage IIA or lower.	15.64	2.41

cancer were detected at stage IIA or lower.[9]			
DLI 2.4 (New) MSPS' instructions for the strengthening of actions for cancer control published.	Added to reflect a new ambitious action plan by the MSPS to improve access to prevention, early detection, and treatment of most prevalent cancers.	--	13.23

Rationale for Changes and their Implication for the Original ToC

19. **Overall, the changes introduced under the third restructuring did not significantly alter the original ToC.** While some of the original DLI milestones were modified, the ones that replaced them maintained the same focus as the original ones, albeit reflecting more closely the GoC's current priorities and vision for the health sector.

II. OUTCOME

A. RELEVANCE

Relevance of PDO

Rating: High

20. **The relevance of the Program's PDOs is deemed High.** The Program's focus on improving the quality of health care services and the efficiency of the health system continues to be relevant in terms of the strategic priorities of both the WB and the GoC. Specifically, the PDOs are aligned with the WB's FY24-27 CPF for Colombia,[10] in particular Objective No. 1 *Improve access to quality services for all*. The Program was also closely aligned with the conclusions of the 2022 Systematic Country Diagnostic Update,[11] which points to staggering inequalities in human capital outcomes, with a need to deliver more effective public services such as health and education to the vulnerable population. Finally, the Program was also aligned with the recommendations of the 2023 Colombia Country Climate and Development Report (CCDR),[12] which emphasizes the importance of building resilience and adaptation through an economy-wide approach. At the institutional level, the Program was closely aligned with core WB priorities and directly contributed to eliminating extreme poverty and boosting shared prosperity on a livable planet. The Program was also aligned with the WB's Human Capital Project and the Gender Strategy 2024-2030, which advocates for greater investments in health and education to improve their populations' productive capacities and end gender-based violence (GBV).[13]

21. **The actions supported under the Program are well aligned with the current strategic priorities of the GoC as reflected in the 2022-2026 PND.** Specifically, one of the PND's goals is to guarantee universal access to effective health services based by, among others, emphasizing the importance of disease prevention, health promotion and risk screening; promoting equitable access to medicines and health care technologies; ensuring the sustainability of health resources;

[9] According to the original FA disbursements for DLI 2.3 - *Increase in the percentage of women with early detection at the time of diagnosis*, were structured as follows: "US$1,469,925 for each 1 percentage point (pp.) of increase in the indicator, above the baseline of 55.7% up to US$15.64 million" (i.e., equivalent to a total increase of 10.65 pp., which, in turns, corresponds to 66.3% of cases detected early). The revised FA was modified to read as follows: "US$1,469,925 for each 1 pp. of increase in the indicator, above the baseline of 49.86% up to US$2.41 million" (i.e., equivalent to a total increase of 1.65 pp., which, in turns, corresponds to 55.1% of cases detected early).

[10] World Bank Group (2024), *Colombia - FY24-27 Country Partnership Framework, Report No. 187535-CO* January 2024, Washington, D.C.: World Bank Group.

[11] World Bank Group (2022), *Colombia - Systematic Country Diagnostic*, Report No. 171460-CO, May 2022, Washington, D.C.: World Bank Group.

[12] World Bank Group (2023), *Colombia - Country Climate and Development Report*, Washington, DC: World Bank Group. [https://openknowledge.worldbank.org/handle/10986/40056]

[13] World Bank (2024), *WB Gender Strategy 2024-2030: Accelerate Gender Equality for a Sustainable, Resilient, and Inclusive Future*, Washington, D.C.: World Bank. [https://documents1.worldbank.org/curated/en/099061124182033630/pdf/BOSIB17e6952570c51b49812a89c05be6a4.pdf]

improving systems of health information and the use of innovative technologies for the delivery of health services; and strengthening environmental health and climate change adaptation and mitigation.

22. **The Program's particular focus on breast cancer under PDO 1 continues to be highly relevant, as it is the type of prioritized cancer that accounts for the largest number of new cases in Colombia (9,484 in 2022), followed by prostate and cervix (5,793 and 3,168 new cases in 2022, respectively).**[14] In addition, it also presented the highest incidence and mortality rates (32.5 new cases per 100,000 inhabitants and 14.67 deaths per 100,000 inhabitants in 2022, respectively).[15] Cancer control also continues to be a top priority of the MSPS, as reflected in the 2022-2031 Ten-Year Public Health, with 29 percent of its targets focusing on cancer control.[16] In addition, together with the National Cancer Institute and the National Health Superintendency, the MSPS adopted a plan to strengthen actions aimed at cancer control in Colombia (the so-called "*Plan de Choque"*) in July 2024.[17] Moreover, PDOI 1 (Percentage of cases of breast cancer that are detected early) is also one of the four indicators corresponding to the health sector in the 2022-2026 PND.

23. **The Program's overall objectives of enhancing quality and efficiency remained consistent with the reforms being proposed by the current administration for the health sector.** The reform proposes reorganizing the health system around PHC centers to strengthen disease prevention and health promotion as well as to reduce disparities between urban and remote rural areas. The reform also aims to improve working conditions for health workers, including better salaries, medical autonomy, enhanced training, continuous professional development, and promotion opportunities, prioritizing those in rural areas. Finally, it also proposes a shift in the administration of public resources from EPSs to the Administrator of the Resources of the General System of Social Security in Health (*Administradora de los Recursos del Sistema General de Seguridad Social en Salud*, ADRES), which would make direct payments to IPSs. EPSs would have two years to transition to the role of third-party administrators, with reduced responsibilities governed by ADRES. This does not imply the disappearance of private or mixed healthcare providers, which would be able to continue offering health services. The reform has not yet succeeded in securing approval in the Senate to become law and continues to be discussed in 2025.

Relevance of DLIs

Rating: Substantial

24. **The Program's DLIs continue to be relevant in the context of the GoC's current health sector priorities.** The Program included four DLIs that provided a solid platform for assessing progress toward the implementation of the government's program, with the individual disbursement milestones focusing on relevant actions contributing to desired institutional change as well as performance outcomes (i.e., early detection of breast cancer, efficiency gains, and migrant SGSSS enrollment). Together, they fully supported the Program's ToC (see Figure 1), providing financial incentives for the achievement of IRs conducive to the PDOs. The criteria by which they were selected contributed to their relevance, including: (i) full alignment with the GoC's priorities as defined in the 2018-2022 PND; (ii) results-focus to stimulate performance; (iii) prioritization of government's routine information systems and existing reporting mechanisms; (iv)

[14] Cuenta de Alto Costo (2024), *Situación del cáncer en la población adulta atendida en el SGSSS de Colombia 2023*, September 2024, Bogotá.
Note: Although referred to as 2023 in the report, the time period being reported corresponds to January 2, 2022, to January 1, 2023. Thus, this ICR reports the data as corresponding to 2022. The same observation applies to all reports by the CAC.
[15] Idem.
[16] [https://www.sispro.gov.co/observatorios/oncancer/Paginas/pdccc.aspx]
[17] [https://www.minsalud.gov.co/Normatividad_Nuevo/Circular%20Externa%20No.%20010%20de%202024.pdf]

balance between ambition ("stretch") and feasibility ("realism"); and (v) an even distribution of disbursements, with disbursements tied to performance outcomes (i.e., early detection of breast cancer and migrant SGSSS enrollment) being designed to be disbursed proportionally to the quantitative achievement of the results (i.e., "scalability").

25. **Those DLIs involving EPS, however, constitute exceptions in terms of continuous relevance, as under the proposed health reform they would no longer be responsible for the administration of public resources.** Changes introduced to the DLIs reflecting changes in relevance are summarized below. It should be noted that the downward revision of the target for the early detection of breast cancer milestone (DLI 2.3) did not represent a change in its relevance. Instead, this revision reflected the negative impact of the COVID-19 pandemic on preventative health care services as well as a revised baseline.

- *DLI 1.2 - New accreditation process for EPSs, including quality standards and quality-assurance processes:* This DLI milestone was revised under the third restructuring, as it would no longer be relevant under the reform being proposed. Instead, a revised DLI 1.2 focusing on quality standards for PHC facilities was introduced to reflect the current PND 2022-2026 objective of strengthening PHC.
- *DLI 2.1 - Design and implementation of an ex-post financial incentive for the EPSs to promote the earlier detection of prioritized cancers, including breast cancer:* While this mechanism, which reallocates financial resources among EPSs based on their performance in cancer care, continues to be relevant under the current legislation, would no longer be relevant under the proposed health reform. It was not modified as part of the third restructuring since it had already been achieved and fully disbursed. Moreover, as discussed below, it has proved to be effective in improving the quality of cancer detection, care, and reporting; thus, it will most likely be adapted to align with the proposed sector reform.
- *DLI 2.4 - Instructions for the strengthening of actions for cancer control in Colombia published:* A new DLI milestone was introduced under the third restructuring (DLI 2.4) focusing on the MSPS's current plan to strengthen cancer prevention, diagnosis, and care to reflect the MSPS' continuous commitment to the fight against cancer.

Rating of Overall Relevance

Rating: Substantial

26. **The overall relevance of the PDOs and DLIs is deemed Substantial to reflect high relevance at the PDO level and substantial relevance at the DLI level.** The PDOs continue to directly support the WB's country-specific and institutional priorities. In addition, although not directly reflected in the 2022-2026 PND, the PDOs of improving the quality of health care services and the efficiency of the health sector indirectly support the PND goal of guaranteeing universal access to effective health services. In addition, the Program' specific focus on the control of breast cancer also continues to be a top public health priority in Colombia. The original DLIs and the majority of the individual disbursement milestones were relevant under both the previous and current administrations. The only exceptions were the ones revised under the third restructuring to ensure continuous alignment with current priorities.

B. ACHIEVEMENT OF PDOs (EFFICACY)

Methodological Notes

27. **The assessment of the Program's efficacy and overall performance under this Implementation Completion and Results Report (ICR) was done in line with the methodology defined in OPS's and IEG's ICR preparation and evaluation guidelines.**[18] Some of the specific considerations include:

- *PDO definition* - As noted earlier, the original PDO is "unpacked" into the following PDOs: PDO 1 - Improving the quality of health services; (ii) PDO 2 - Improving the efficiency of the health system. In addition, the efficacy assessment under each PDO distinguishes between the main areas of support under individual DLIs.
- *Split evaluation* - The adjustments to the PDOI 1's baseline and target introduced under the third restructuring call for the application of the split methodology. Therefore, the assessment of the Program's efficacy is done taking into consideration two periods: (i) Period 1, which extends from the Program's approval to the date of the third restructuring (December 20, 2024), is assessed based on the achievement of the original RF and DLI targets; and (ii) Period 2, which extends from December 20, 2024 to the Program's closing, is assessed with respect to the revised RF and DLI targets.
- *Achievement of revised DLI targets* While all the DLI targets that were revised under the third restructuring have been met, disbursements amounting to US$ 33.23 million are still pending contingent upon the submission of the external verification report by the National Planning Department *(Departamento Nacional de Planeación,* DNP), which is expected to be completed by August 2025.[19] For the purpose of this ICR, they are considered as achieved, while noting that disbursements are still pending.
- *Period of analysis* Even though the PforR became effective in December 2020, in some cases this ICR examines trends from 2018 onward (as opposed to 2019) given that: (i) the PforR supported the 2018-2022 PND; (ii) some of the original baselines corresponded to 2018 (i.e., PDOI 1); (iii) some DLI milestones were prior actions; thus, they were fulfilled prior to the signing of the FA (i.e., DLIs 1.1, 2.1, 3.1, 4.1); and (iv) the impact of actions implemented under the 2018-2022 PND, including prior results supported under this PforR, was already evident in 2019.
- *Additional evidence* – The efficacy assessment relies on the Program's RF as well as complementary additional evidence, particularly in relation to outcomes under PDOI 1 during Period 1.

Assessment of Achievement of Each PDO Outcome

PDO 1. To support improvements in the quality of healthcare services.

Rating: Substantial (for both Periods 1 and 2)

28. The Program provided financial incentives for policy actions (i.e., regulations, technical studies) aimed at improving the quality of health care services and resulting in measurable outcomes. There were two distinct areas of focus under PDO 1: (i) improvements in the quality of care through regulation (DLI 1); and (ii) improvement in in quality of care through payment incentives, with a particular emphasis on the detection of breast cancer (DLI 2). PDO achievement for the two areas of focus is assessed separately under DLI 1 and DLI 2, respectively.

DLI 1. Improvements in the quality of care through regulation.

[18] World Bank (2021), *Bank Guidance - ICR for PforR Operations*, OPS5.04-GUID.119, Operations Policy and Country Services, December 13, 2021, Washington, D.C.: World Bank Group. Independent Evaluation Group (2024), *Guidance Manual for Validators: ICR Reviews for Investment Project Financing (IPFs) (Vol. 1),* Washington, D.C.: World Bank Group.

[19] The verification report for DLRs 1.2 and 2.4 has been submitted to the Bank and deemed acceptable. Disbursement request for the corresponding US$30.82 million is under preparation by the Minister of Finance and is expected in June 2025. For DLR 2.3, the DNP has requested additional information to the MSPS to verify its accomplishment. For this reason, an extension of the grace period till August 30,2025 for disbursements amounting to US$2.41 million will be requested by the Minister of Finance.

29. **Definition.** As originally envisioned (i.e., Period 1), the Program included financial incentives aimed at improving the quality of health services at the system level under DLI 1. Specifically, disbursements under DLI 1 were tied to the updating of certification standards for IPSs, new accreditation processes for EPSs, and new quality standards and simplified accreditation processes for low-complexity hospitals (DLIs 1.1, 1.2, 1.3, respectively). In turn, the adoption of these certification and accreditation standards were expected to lead to improvements in the quality of health care services at the system level. The RF did not include a PDOI focusing specifically on quality improvements resulting from the updated certification and accreditation standards.

30. As revised under the third restructuring (i.e., Period 2), the original milestone under DLI 1.2 (i.e., adoption of new accreditation processes for EPSs) was replaced with a new one (i.e., adoption of quality standards for PHC facilities) to reflect both the uncertainty regarding the future role of EPSs and the primary importance given to primary care under the proposed health reform.

31. **Results.** The Program's contribution toward improving the quality of health care services through regulation is deemed Substantial for both Periods. The main results under both Periods included the adoption of new registration and licensing standards for IPSs (DLI 1.1) that determine minimum capacity standards (e.g., infrastructure, human resources, medical equipment, etc.) to be registered as a health care provider and licensed to provide specific health care services.

32. As of December 2024, there were 6,340 registered IPSs and 27,305 licensed services.[20] New quality standards and simplified processes were also adopted for the accreditation of low-complexity hospitals (DLI 1.3), with 132 of them receiving TA (compared to the target of 60). In addition, quality standards were adopted for PHC facilities during Period 2 (revised DLI 1.2), complementing the registration and licensing standards of IPSs adopted during Period 1. Other achievements included: the development of a prioritization mechanism to update the benefits plan, and the adoption of new regulations for the training of health staff on continuous quality improvements, telemedicine, and the interoperability of the electronic health records.

33. During Period 2, all milestones (DLI 1.1, revised 1.2, 1.3) and all IRIs (4, 5, 6, and 8) were achieved; thus, efficacy is deemed substantial. During Period 1, two out the three milestones (DLI 1.1 and 1.3) and all but one IRI were achieved. Although the original milestone DLI 1.2 and IRI 1 were not achieved given its lack of relevance under the proposed health reform, efficacy is still considered to be substantial given the anticipated impact of milestones DLI 1.1 and 1.3 on the quality of services provided by IPSs and low-complexity hospitals. Although direct attribution cannot be established, the actions supported under the Program likely contributed to reduced waiting times as well as the increase in patients' overall satisfaction with the health care services they received, as shown below under additional evidence. Specific results are summarized in Table 5:

Table 5. Improvements in the quality of care through regulation

DLI 1 - Improvements in the quality of care through regulation		
IRs AND OUTPUTS	Target Achievement (%)	
	Period 1	Period 2
• **DLI 1.1** Updated certification standards for IPSs	Achieved	

[20] As of December 2024, 6,340 out of a total of 19,533 IPSs were registered and 27,305 out of a total of 230,628 services were licensed under the new registration and licensing standards, as reported by the MSPS' Directorate of Service Provision and Primary Care (*Dirección de Prestación de Servicios y Atención Primaria*) during the ICR mission.

Periods 1 & 2 Achieved: This milestone was achieved with the publication of Resolution 3100/2019.[21] This Resolution revised the minimum capacity requirements to for IPS to be registered as health care providers and the licensing standards for individual health care services, including: (i) human resources; (ii) infrastructure; (iii) equipment; (iv) medications, medical devices, and supplies; (v) priority processes (i.e., clinical protocols); (vi) medical history and records; and (vii) interdependence.[22] Some notables changes with respect to its predecessors include the definition of standards for extramural medical services (e.g., vaccination campaigns), new technologies (e.g., telemedicine) as well as environmental management. As of December 31, 2024, there were 6,340 registered IPSs and 27,305 licensed health care services.		
• **Revised DLI 1.2** New quality standards for PHC facilities *Period 2* - Achieved: This milestone was achieved with the publication of MSPS Resolution No. 2696/2024.[23] This norm defines quality standards for health care providers (IPSs, EPs, and Territorial Entities) with a focus on the following attributes: access, opportunity, coordination, safety, relevance, continuity, sustainability, and coordination. The DNP verified its accomplishment in May 2025 and the corresponding disbursements will be done in June 2025.	N.A.	Achieved (*)
• **Original DLI 1.2** Definition of revised processes and standards for the accreditation of EPSs *Period 1* - Not Achieved: This milestone was not achieved. *Period 2* - Not Applicable: This milestone was eliminated under the third restructuring given the uncertainty regarding the future role of the EPSs in the context of the proposed health reform.	Not Achieved	N.A.
• **DLI 1.3** Regulation defining quality standards and simplified processes for the accreditation of low-complexity hospitals *Periods 1 & 2* - Achieved: Regulation No. 1328 determining new standards for the accreditation of low-complexity hospital was issued on August 30, 2021. These standards have a focus on primary care, and family and community health, with an emphasis on the implementation of comprehensive health service delivery networks. It should be noted that this accreditation is voluntary, except for university hospitals. No low-complexity hospital has been yet accredited.	Achieved	
• **IRI 3** Technical assistance (TA) for low-complexity hospitals (Baseline: 2; Target: 60). *Periods 1 & 2* - Exceeded: The number of low-complexity public hospitals that received TA in their accreditation process increased from 2 to 132, amply exceeding the end-target (equivalent to 224 percent level of achievement with respect to 60 percent target).	224%	
• **IRI 1** Ministerial decree on the SOGC has been approved and issued *Period 1* - Not Achieved: The corresponding decree was prepared, which entailed a laborious process involving technical work, the endorsement of scientific societies, and a series of public consultations with scientific societies. Nevertheless, the IRI was eliminated under the third restructuring due to shifting government priorities, with the new focus being on defining enhanced quality standards for PHC providers. *Period 2* - Not Applicable	Not Achieved	N.A.
• **IRI 4** Regulation on training health care personnel in continuous quality improvement *Periods 1 & 2* - Achieved: Decree 376 defining training of health staff aimed at improving the skills and problem-solving capacity to ensure the delivery of quality health care services was issued on March 14, 2022. In 2024, in collaboration with the Pan American Health Organization	Achieved	

[21] https://www.suin-juriscol.gov.co/viewDocument.asp?ruta=Resolucion/30039964#:~:text=RESOLUCION%203100%20DE%202019&text=(noviembre%2025)-,por%20la%20cual%20se%20definen%20los%20procedimientos%20y%20condiciones%20de,Habilitación%20de%20Servicios%20de%20Salud.
[22] https://www.suin-juriscol.gov.co/imagenes//19/10/2020/1603145521732_Anexo%20técnico%20de%20la%20Resolución%20No.%203100%20de%202019.pdf
[23] https://www.minsalud.gov.co/Normatividad_Nuevo/Resolución%20No%202696%20de%202024.pdf

(Organización Panamericana de la Salud, OPS) and Colombia's National Learning Service *(Servicio Nacional de Aprendizaje*, SENA), an online education platform was developed to expand the supply of no-cost training offerings.[24]	
• **IRI 5** Regulation on interoperability (IO) standards for electronic health records *Periods 1 & 2* - Achieved: Regulation 866 defining IO standards for the clinical data required in electronic health records was issued on June 25, 2021.[25]	Achieved
• **IRI 6** Regulation on the use of telemedicine *Periods 1 & 2* - Achieved: Regulation No. 2654 defining guidelines on the use of telemedicine to improve access to quality care was issued on October 3, 2019.[26] There were further norms issued in 2020 to expand the provision of services using telemedicine during the pandemic, as well as in 2023 to define standards for the human resources for the provision of services via telemedicine in rural areas. Expanding the use of telemedicine is a top priority under the 2022-2026 PND, which aims to increase the percentage of IPS licensed to provided services via telemedicine from 8.84 percent in 2022 to 50 percent in 2026.	Achieved
• **IRI 8** Development of a prioritization mechanism to update the benefits plan *Periods 1 & 2* - Achieved: The document outlining the health risk adjustment methodology was published in May 2022.[27] However, its implementation has not yet been approved by the advisory committee, given the fiscal implications in the context of budgetary adjustments.	Achieved

(*) The corresponding disbursements are still pending.

34. **Additional Evidence.** Although a direct attribution cannot be established, the regulations and TA supported under the Program likely contributed to increased patient satisfaction as well as reductions in waiting time reported by public hospitals.

35. *Patient satisfaction with health care services:* As shown by the annual patient satisfaction survey conducted by the MSPS, the percentage of patients reporting a "good" or "very good" overall experience regarding the health services received through the EPS increased from 69.4 percent in 2019 to 72.9 percent in 2023. Although this indicator also reflects the administrative performance of EPSs, it can be expected to reflect patients' satisfaction with the quality of health care services provided by the IPSs.[28]

36. *Waiting times*: There were significant reductions in waiting time in public hospitals during the Program's lifetime. Specifically, the average waiting time for care for a patient classified as Triage 2 in the emergency room decreased from 46 to 40 minutes between December 2019 and September 2023. Likewise, the average waiting time for the assignment of a general medicine appointment decreased from 2.27 days to 1 day between September 2019 and March 2024. [29]

DLI 2. Improvements in the quality of care through payment incentives.

37. **Definition.** As originally envisioned (i.e., Period 1), the Program supported the introduction of payment incentives to achieve higher quality of care and efficiency under DLI 2. Specifically, disbursements under DLI 2 were tied to the implementation of *ex-post* financial incentives for EPSs to achieve higher standards of access and quality of care for cancer

[24] https://www.funcionpublica.gov.co/eva/gestornormativo/norma_pdf.php?i=184269
[25] https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/resolucion-866-de-2021.pdf
[26] https://www.minsalud.gov.co/normatividad_nuevo/resoluci%C3%B3n%20no.%202654%20del%202019.pdf
[27] https://www.minsalud.gov.co/salud/POS/Paginas/resultados-pos.aspx
[28] MINSALUD, Oficina de Calidad (2019; 2023), *Estudio Nacional de Evaluación de los Servicios de las EPS 2019 y 2023.*
[https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/CA/evaluacion-servicios-salud-informe-final-II2019.pdf]
[https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/CA/resultados-encuesta-satisfaccion-usuarios-sistema-salud-colombiano-enfasis-atencion-primaria.pdf]
[29] https://sig.sispro.gov.co/sistemaalertashospitales/

(DLIs 2.1, 2.2). While the implementation of such mechanisms impacted cancer care for 11 priority types of cancer,[30] the RF focused specifically on early detection of breast cancer (PDOI 1/ DLI 2.3), given the higher incidence rate of this type of cancer. Furthermore, screening plays a crucial role in detecting breast cancer, as it is the primary method of identification,[31] significantly influencing survival rates.

38. **Results.** The Program's contribution toward improving quality of care through the introduction of payments incentives is deemed substantial for both periods. MSPS Resolutions No. 3339/2019 and 1620/2020 (DLI 2.1) provided *ex-post* financial incentives to EPSs to improve the quality of cancer care and reporting. Specifically, the risk adjustment methodology implemented under these resolutions replaced the one previously utilized by the MSPS for the distribution of the capitation payments, which included only basic variables such as gender, age group and place of residence. Conversely, the new formula calculates *ex-post* adjustments based on the actual performance of individual EPSs with respect to a battery of quality indicators defined for each type of cancer focusing on early diagnosis, treatment, and palliative care as well as health outcomes (i.e., incidence and early mortality).[32] These indicators, together with the corresponding targets were determined by consensus by the medical and academic communities and validated by the MSPS and international standards (DLI 2.1). The newly implemented *ex-post* incentives, together with the GoC's strategic efforts to combat cancer under the 2012-2021 Ten-Year Plan for Cancer Control in Colombia and the subsequent *Plan de Choque* (DLI 2.4) are likely to have contributed to greater access and quality for cancer detection including screening according to clinical protocols with mammograms (IRI 2), as well as significant improvements in reporting. Significant increases were also seen in the absolute number of: (i) new cases being detected and reported; (ii) new cases that underwent tumor staging testing; and (iii) new cases detected early. There were also substantial improvements in the opportunity of diagnosis and treatment. These improvements, in turn, had resulted in positive health outcomes, as shown by PDOI 1 - Increase in the percentage of new breast cancer cases diagnosed earlier from 49.86 percent in 2019 to 55.95 percent in 2023.[33] These improvements are particularly notable in the context of the COVID-19 pandemic, which negatively affected the delivery of routine health care services worldwide, including breast cancer diagnosis.

39. All DLIs and IRIs were met or exceeded. The only exception was PDOI 1/DLI 2.3 (i.e., increase in the percentage of new cases detected early) for Period 1, as the significant increase in the number of cases detected early was offset by an even more significant increase in the number of new cases being diagnosed and reported. The corresponding revised targets were achieved for Period 2. Specific achievements under the original and revised RF are summarized in Table 6. Additional evidence showing improvements in the quality of breast cancer diagnostic services as well as comparisons with global cancer indicators is also summarized below and presented in greater detail in Annex 5.

Table 6. Improvements in the quality of care through payment incentives

DLI 2 - Improvements in the quality of care through payment incentives		
OUTCOMES	Target Achievement (%)	
	Period 1 -	Period 2
Improvements in health outcomes		

[30] The definition of priority cancers was based on epidemiological perspective, disease burden and interest in public health. The types of cancer designated as priority included: (i) breast cancer; (ii) cervical cancer; (iii) colon and rectal cancer; (iv) stomach cancer; (v) prostate cancer; (vi) trachea, bronchus, and lung cancer; (vii) acute lymphoid leukemia in children; (viii) acute lymphoid leukemia in adults; (ix) acute myeloid leukemia in children; (x) acute myeloid leukemia in adults; and (xi) non-Hodgkin lymphoma in adults.

[31] The five major cancer types vary in how they are typically detected: through screening (female breast and prostate cancer), due to symptoms (lung and bronchus and pancreatic cancer), or incidentally during other medical procedures (thyroid cancer).

[32] See MSPS Resolutions No. 3339/2019 for a detailed description of the calculations that determine the monetary incentives. [https://cuentadealtocosto.org/wp-content/uploads/2020/02/resolucion-no-3339-de-2019.pdf]

[33] Preliminary value for 2023 based on audited data reported by EPS to the High-Cost Account (*Cuenta de Alto Costo* – CCA). The official statistic, which is not expected to change significantly, will be released in June-July 2025 after verification by the MSPS.

• **PDOI 1& DLI 2.3 -** Percentage of women with breast cancer detected in early stage (Stage IIA or earlier) (Original baseline: 55.7 in 2018; Revised baseline: 49.86 in 2019; Original target: 69; Revised target: 55). *Period 1* - Not Achieved: Due to several methodological reasons as well the negative impact of the COVID-19 pandemic, in December 2023 this indicator was still roughly the same as the original 2018 baseline. When examining the trends in absolute terms rather than as a percentage, there was a significant increase in the number of cases being detected early (stages I and II) between 2018 and 2022 (from 2,663 to 5,040--equivalent to an 89.3 percent increase). This increase, however, was offset by an even more rapid increase in the number of reported new breast cancer cases (95.3 percent) between 2018 and 2022, which obscured the impact of the actions supported under this Program (see also Annex 5).[34] *Period 2* - Exceeded The percentage on new breast cancer cases detected early increased by 6.09 pp. from 49.86 percent in 2019 to 55.95 percent[35] in 2023 (equivalent to 118 percent of achievement with respect to the 55 percent target). DNP external verification of the revised DLI 2.3 and the corresponding disbursements are still pending and expected to be completed in August 2025.	2%	118%
Improvements in access and quality in service provision		
• **IRI 2** Breast cancer screening with mammogram (Baseline: 21.2 percent; Target: 30 percent). *Periods 1 & 2* - Exceeded: The percentage of women 50-69 years of age screened for breast cancer according to defined protocols increased from 21.1 percent to 37.92 percent [36] between 2019 and 2023 (equivalent to 190 percent level of achievement with respect to 30 percent target).	190%	
IRs AND OUTPUTS		
• **DLI 2.1** Design and implementation of an *ex-post* financial incentive for the EPSs to promote the earlier detection of prioritized cancers, including breast cancer. *Periods 1 & 2* - Achieved: This milestone was achieved with the publication of Resolutions 3339/2019[37] and 1620/2020.[38]	Achieved	
• **DLI 2.4** Action plan for the control of cancer. *Period 2* - Achieved: The latest MSPS' action plan for strengthening the control of cancer (*Plan de Choque*) was adopted on July 2, 2024.[39] DNP verified its accomplishment in May 2025 and the corresponding disbursements will be done in June 2025.	N.A.	Achieved
• **DLI 2.2** Technical review of risk-adjustment methodology of the UPC. *Periods 1 & 2* - Achieved: The technical review of the risk adjustment methodology of the UPC was completed and published in May 2022.[40] However, its implementation was not approved by the advisory committee, given the fiscal implications in the context of budgetary adjustments.	Achieved	

40. **Additional evidence.** The trends of indicators focusing on the screening, diagnosis and reporting of breast cancer from 2018 (original baseline) to 2022 (latest data available) show significant improvements in both access and quality.

[34] Other reasons that obscure improvements in the early detection of breast cancer cases as reflected by PDOI 1 during Period 1 were: (i) a high percentage of breast cancer cases detected early in 2018 as a result of an atypically low number of reported new breast cancer cases during the same year (i.e., a smaller denominator); and (ii) an unrealistic end-Project target that reflected the one included in the 2018-2022 PND.
[35] Preliminary value for 2023 based on audited data reported by EPS to the CCA. The official statistic will be released in May-June 2025 after verification by the MSPS.
[36] https://web.sispro.gov.co/WebPublico/Consultas/MonitorRIAS.aspx
[37] https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%20No.%203339%20de%202019.pdf
[38] https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/resolucion-1620-de-2020.pdf
[39] https://www.minsalud.gov.co/Normatividad_Nuevo/Circular%20Externa%20No.%20010%20de%202024.pdf
[40] https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VP/DOA/condiciones-salud-upc-incentivos-calidad-resultados-salud-2022.pdf

Specifically, substantial improvements are shown in the absolute number of: (i) new cases being detected and reported on an annual basis (i.e., 95.3 percent increase between 2018 and 2022); (ii) new cases that underwent tumor staging testing (i.e., 85.7 percent between 2018 and 2022); and (iii) new cases detected early (i.e., 88.6 percent between 2018 and 2022). There were also substantial improvements in the opportunity of diagnosis and treatment. Also notable is the fact that the increase in the number of new breast cancer cases reported in Colombia between 2018 and 2022 was nine-fold higher than globally, pointing to the significant magnitude of such increase.[41] These trends are summarized in Annex 5.

41. The significant increase in new diagnoses is particularly noteworthy in the context of the COVID-19 pandemic and its negative impact on the provision of health care services. As an illustration, in Colombia, the number of pediatric consultations for boys and girls decreased by 29 percent and 25 percent, respectively, in 2020 with respect to the 2018-2019 average.[42] Notably, the COVID-19 pandemic had a lesser impact on the delivery of care for breast cancer. Specifically, the number of new breast cancer cases dropped by only 6.4 percent (from 7,047 to 6,593 new cases) between 2019 and 2020, and rapidly bounced back in 2021, exceeding the pre-pandemic values (8,018 new breast cancer cases diagnosed in 2021 vis-à-vis 4,855 and 7,047 in 2018 and 2019, respectively). The same can be observed in the number of tumor staging tests performed (7,181 tumor staging tests conducted in 2021 vis-à-vis 4,503 and 6,295 in 2018 and 2019, respectively) and the number of new breast cancer cases detected early (4,768 breast cancer cases detected early in 2021 vis-à-vis 3,082 and 4,283 in 2018 and 2019, respectively).[43] The actions implemented by the MSPS to combat cancer with the support of this Program most likely played a determinant role in ameliorating the impact of the pandemic on cancer care.

42. While this Program focused specifically on early detection of breast cancer, it is important to note that the impact of the GoC's strategic actions to control cancer, including the adoption of *ex-post* financial incentives for 11 priority types of cancer, are expected to have positively impacted all cancers. The significant increase in the number of new cases of cancer (all types) diagnosed and reported in Colombia vis-a-vis the increase globally serves as an illustration. While in Colombia, the number of new cancer cases (all types; *in situ* and invasive) reported doubled between 2018 and 2022 (from 29,151 to 58,813), it increased by only 10.5 percent worldwide (from 18.1 million to 20 million) during the same period. [44]

PDO 2. To support improvements in the efficiency of the health system.

Rating: Substantial (for both Periods 1 and 2).

43. The Program aimed to improve the efficiency of Colombia's health system (PDO 2), providing support to two distinct areas of focus: (i) increased efficiency in pharmaceutical spending (DLI 3); and (ii) the enrollment of eligible migrants to the SGSSS (DLI 4). PDO achievement for the two areas of focus is assessed separately under DLI 3 and DLI 4, respectively.

DLI 3. Increased efficiency in pharmaceutical spending through regulatory policies of pharmaceutical markets.

44. **Definition.** The Program provided support for regulatory actions and studies aimed at managing pharmaceutical spending and expanding access to medicines. Disbursements were tied to the public consultation on the methodology for the regulation of prices of medicines (DLI 3.1), the application of the existing price regulation methodology to at least 50

[41] GLOBOCAN, 2020, 2022. [https://doi.org/10.3322/caac.21492] [doi:10.3322/caac.21834]
[42] World Bank (2023), *Building Resilient Health Systems in Latin America and the Caribbean: Lessons Learned from the COVID-19 Pandemic,* Washington, D.C.: World Bank Group.
[https://documents1.worldbank.org/curated/en/099805001182361842/pdf/P1782990d657460cb0a2080ac0048f8b98f.pdf]
[43] Cuenta de Alto Costo (2019-2024), *Situación del cáncer en la población adulta atendida en el SGSSS de Colombia – 2018-2023*, Bogotá.
[https://cuentadealtocosto.org/cancer/]
[44] GLOBOCAN, 2020, 2022.

relevant markets (DLI 3.2); the definition of a methodology for determining the price of new high-cost drugs entering the market (i.e., so-called "*puerta de entrada"*). In turn, the impact of these regulatory measures was expected to result in efficiency gains of at least COP 800 billion between the 2018-2022 period (PDO 3/DLI 3.4). There were no changes introduced to this area of support during the Program's lifetime.

45. **Results.** The Program's contribution toward improving the efficiency of the health system by controlling pharmaceutical spending is deemed substantial. The application of existing regulation to an additional 239 drugs resulted in an average price reduction of 48 percent [45] and COP946 billion in cost savings during the 2020-2022 period, exceeding the original projected goal of COP 800 billion (PDO 3). Additionally, the methodology for controlling and regulating the introduction of high-cost medications into the market was issued in 2023 (Circular 16/2023), in compliance with Article 72 of Law 1753 of 2015 (eight years after it was enacted). In addition, the 2013 methodology for regulating drug prices under the direct price control regime was updated in 2024 (Circular 18/2024) after five previous attempts, establishing a maximum sale price for drugs applicable to all entities involved in the purchase and sale of drugs, both institutionally and commercially. Finally, in a landmark move for public health and access to affordable HIV medication, Colombia issued its first-ever compulsory license for Dolutegravir in 2024, allowing the country to access generic versions of the drug without the patent owner's permission, paving the way for domestic production or imports.

46. All DLI milestones and IRIs were met or exceeded. Other achievements included the carrying out and publication of three additional technical studies, which provided the technical basis for the regulation of medical devices as well as a deeper understanding of the impact of out-of-pocket household expenditures on medications. [46] There were also significant improvements regarding the simplification of administrative procedures, such as the elimination of the requirement to renew the sanitary registration of drugs[47] (previously every five years) and new simplified procedures for the modification of existing sanitary registries. There were also improvements in the timeliness of drug-related information under the MSPS' Drug Price Information System *(Sistema de Información de Precios de Medicamentos*, SISMED), which is now updated on monthly basis (before it was quarterly). Also notable was the implementation of the Drug Price Thermometer, an online tool that enhances overall transparency and helps eliminate information asymmetries in the market for pharmaceutical drugs.[48] Specific achievements are summarized in Table 7. Additional evidence on the impact of regulation on cost savings and access to pharmaceutical drugs is also presented below.

[45] Departamento Nacional de Planeación (2023), *Plan Nacional de Desarrollo 2018-2022 - Balance de resultados 2022*. [https://colaboracion.dnp.gov.co/CDT/Sinergia/Documentos/Balance_de_resultados_2022_vf.pdf]

[46] Including: (i) coronary endovascular medical devices; (ii) contraceptive medical devices; and (iii) out-of-pocket household spending on pharmaceutical drugs.

[47] The sanitary registry of drugs, or drug registration, is the process by which pharmaceutical products undergo evaluation and analysis by health authorities to ensure they meet quality, efficacy, and safety standards before being marketed.

[48] The Drug Price Thermometer is an online tool for comparing prices and understanding the supply of medications containing the same active ingredient, strength, and dosage. It visually displays medications with low prices (green), medications with normal prices (yellow), and medications with high prices (red) based on prices reported by pharmaceutical companies to SISMED. [https://www.minsalud.gov.co/salud/MT/Paginas/termometro-de-precios.aspx]

Table 7. Increased efficiency in pharmaceutical spending through regulatory policies of pharmaceutical markets

DLI 3 - Increased efficiency in pharmaceutical spending	
OUTCOMES	**Target Achievement (%)**
• **PDOI 3 & DLR 3.4** Efficiency gains achieved over the period 2020 - 2022 with new regulations in the pharmaceutical market (Baseline: COP 0; Target: COP 800 billion) Exceeded: Expenditure containment measures regulating the price of pharmaceutical drugs resulted in COP 946 billion—approximately US$255 million[49]--in cost savings during the 2020-2022 period, exceeding the target (equivalent to 118 percent level of achievement with respect to target of COP 800 billion).	118%
IRs AND OUTPUTS	
• **DLI 3.1** Public consultation of the methodology for the regulation of prices of medicines Achieved: Public consultations were conducted in 2019, 2022 and 2023, leading to the update of the 2013 methodology for the application of the direct price control regime for medicines marketed in the national territory (Circular 3/2013, replaced by Circular 18/2024). [50]	Achieved
• **DLI 3.2** Application of the existing price regulation methodology to at least 50 relevant markets Exceeded: Circular 13/2013[51]was applied to a total of 139 relevant drug markets, amply exceeding the target (equivalent to 278 percent level of achievement with respect to target of 50).	278%
• **DLI 3.3** New methodology to control the introduction of high-cost drugs in the market (*Puerta de entrada*). Achieved: This milestone was achieved with the issuing of Circular 16/2023, which regulates the price of new high-cost drugs entering the market in accordance with their therapeutic value. [52]	Achieved
• **IRI 11** Publication of analysis of the pharmaceutical market for the incorporation of medicines and medical devices into the probation regime. (Baseline: 1; Target: 4). Achieved: A total of four technical studies were carried out, providing the technical basis for the regulation of medical devices and a deeper understanding of the impact of out-of-pocket household expenditures on medications.[53]	Achieved

47. **Additional Evidence.** To complement the evidence presented above that focused on the impact of drug cost controls during the 2020-2022 period, the impact of cost control measures was also analyzed for the ten drugs representing the highest amount of sales (i.e., value) in 2023. Specifically, based on SISMED sales data for the 2019-2023 period and prices before and after regulation (2019 and 2023, respectively),[54] COP 138 billion in savings were estimated in these ten top markets alone in 2020, COP 143 billion in 2021, COP 223 billion in 2022, and COP 232 billion in 2023

[49] Based on the average annual exchange rate for the 2020-2022 time period.
[50] https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/circular-018-de-2024.pdf
[51] https://www.minsalud.gov.co/salud/MT/paginas/medicamentos-regulacion-precios.aspx
[52] ttps://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/circular-externa-16-de-2023.pdf
[53] Including: (i) coronary endovascular medical devices; (ii) contraceptive medical devices; and (iii) out-of-pocket household spending on pharmaceutical drugs.
[54] Savings from Cost Containment Measures = (Price before regulation × Units sold in the calculation year) - (Price after regulation × Units of the calculation year). The price before regulation corresponds to the sales price reported by the drug company or importer in 2019, which was considered when performing the calculations that support Circular 10 of 2020. The price after regulation corresponds to the average sales price reported to SISMED by the manufacturer or importer after the maximum sales prices established in Circular 10 of 2020 came into effect. It is important to note that, instead of using the Maximum Sales Price, the decision was made to use the average price, given that, in some cases, the reported prices may be below the regulated price, which allows for a more accurate estimate of the cost containment result. Data provided by the MSPS's Directorate of Medications and Health Technologies.

(equivalent to CO 736 billion for the 2020-2023 period). Based on these data (i.e., 4 percent increase in cost savings between 2022 and 2023) and the COP 406 billion in cost savings reported for all drugs in 2022 as a result of the actions of the pharmaceutical policy,[55] it is estimated that COP 422 billion were saved in all regulated drugs in 2023. Adding the estimated 2023 amount (COP 422 billion) to the one accumulated during the 2020-2023 period (COP 946 billion) results in cumulative savings of COP 1,368 billion—approximately US$350 million[56]--during the 2020-2023 period.[57] Equally important is to underscore that the regulation of drug prices has not resulted in shortages. As of December 2024, out of a total of 218 drugs monitored by Colombia's National Institute for Food and Drug Surveillance (*Instituto Nacional de Vigilancia de Medicamentos y Alimentos*, INVIMA), only seven drugs were out of stock, and five were at risk of being in shortage.[58]

DLI 4. Number of eligible migrants affiliated to health insurance scheme.

48. **Definition.** The Program provided support for affiliation of eligible migrants, the majority of them from crisis-stricken Venezuela, into the SGSSS. In addition to expanding access to health care services for eligible migrants, their SGSSS affiliation was important from an efficiency perspective for several reasons, including: (i) increasing the pools of risk and resources by ensuring their affiliation to the mandatory social security system; (ii) reducing the demand of already overburdened emergency services by expanding access to PHC services, including screening and diagnostic services, which are pre-paid and often subsidized; and (iii) preventing the transmission of vaccine preventable diseases. Disbursements were tied to a MSPS's resolution defining the conditions under which migrants were eligible to access health care services in Colombia and processes to be enrolled in the SGSSS (DLI 4.1) and targets in terms of the cumulative number of migrants being affiliated (i.e., 139,500; 197,000; and 225,250 migrants for DLIs 4.2, 4.3, and 4.4, respectively). There were no changes introduced to this area of support during the Program's lifetime.

49. **Results.** The Program's contribution toward efficiency by supporting the enrollment of eligible migrants to the SGSSS is deemed substantial. In January 2020, Decree 64 was issued, recognizing the Venezuelan migrant population identified with PEP as beneficiaries of the SGSSS. The DLI 4.4 cumulative target was achieved in 2020, with 260,721 eligible migrants enrolled with the Program's support. As of November 2024, 1,560,374 migrants were enrolled in the SGSSS (81 percent in the subsidized system and 19 percent in the contributory system).

50. All DLI targets and IRIs were met or exceeded. Specific achievements are summarized in Table 8.

Table 8. Affiliation of Eligible Migrants to the SGSSS

DLI 4 - Enrollment of eligible migrants to the SGSSS OUTCOMES	Target Achievement (%)
• **DLI 4.2 thru 4.4** SGSSS enrollment of eligible Venezuelan migrants with the Program's support (Baseline: 0; Target: 225,250). Exceeded: The DLI 4.4 cumulative target was achieved in 2020, with of 260,721 eligible migrants enrolled with the Program's support (equivalent to 116 percent level of achievement with respect to target of 225,250). As of November 2024, 1,560,374 migrants were enrolled in the SGSSS with the support of the WB under this PforR, the IDB and the GoC.	116%

[55] DNP (2023), *Plan Nacional de Desarrollo 2018-2022 - Balance de resultados 2022*.
[56] Based on the average annual exchange rate for the 2020-2023 period.
[57] Cost savings for all drugs (including ten top markets) for 2023 as well as the total for the 2020-2023 period were estimated by the ICR author based on data provided by the MSPS.
[58] [https://invima.gov.co/sites/default/files/medicamentos-productos-biologicos/Desabastecimientos/2024/Establecimientos/listado_abastecimiento_y_desabastecimiento_medicamentos_diciembre_de_2024_-_publicado.pdf]

IRs AND OUTPUTS	
• **DLI 4.1** Revised conditions for SGSSS enrollment for PEP-holding Venezuelan migrants Achieved: Decree No. 64 facilitating the enrollment of eligible Venezuelan migrants was issued on January 20, 2020. [59]	Achieved
• **IRI 12** Number of departments with strengthened capabilities to allow the affiliation of migrants to the SGSSS (Baseline: 0; Target: 24). Achieved: All 24 departments received TA to strengthen their capabilities to support the enrollment of Venezuelan migrants to the SGSSS, with a focus on protocols for service delivery and rights for repatriated, displaced population and migrants.	100%

Other complementary results and actions monitored under the RF in relation to PDO 2

51. **Although without direct financial support under the Program, other complementary results and actions included under the 2018-2022 PND and MSPS's health plan were monitored under the RF.** These actions, which were seen as contributing to the overall efficiency of the health system, included: (i) improvements in performance of public hospitals as reflected in the Performance Index (PI) (PDOI 2); (ii) increase in the frequency of PI reports; (iii) the roll-out of pilots for pre-judicial agreements to new departments; and (iv) increase in the percentage of citizen consultations and claims submitted through the MSPS internet site solved on time. As shown in Table 9, results were mixed, as there was limited progress in expanding pre-judicial agreement mechanisms and the timely resolution of consultations from the public.

52. **Although it is formally a PDO Indicator, this ICR does not consider PDOI 2 (i.e., the PI of public hospitals) in the efficacy assessment of PDO 2, due to challenges in establishing both its achievement and its attribution.** As detailed in Annex 5, the target for PDOI 2 can be interpreted as either achieved or not achieved depending on the measurement approach, given the indicator's high intra-annual variability. Furthermore, the PI is a composite indicator comprising a wide range of sub-indicators focused on the public health performance of territorial entities, service quality, and the financial sustainability of public hospitals. As a result, it is difficult to draw a clear causal link between improvements in the Index and the specific actions and financial incentives supported under this PforR.

Table 9. Other actions and results under PDO 2

PDO 2 Other actions and results	
OUTCOMES	Target Achievement (%)
• **PDOI 2 -** Performance Index (PI) for public hospitals (Ai Hospitals) (Baseline: 61 percent in March 2019; Target: 70 percent). *Period 1 & 2* – Undetermined: PDOI 2 can be considered either achieved or not achieved depending on when it is measured. Specifically: Achieved: The overall PI increased from 65.9 to 75.88 (i.e., equivalent to almost 10 pp. increase) between December 2018 and December 2023, amply exceeding the 70 percent target. Not Achieved: When considering the annual average, the PI decreased from 73.06 to 72.42 between 2019 and 2023. While experiencing some drops and rebounds, the annual average was consistently above the target of 70.	Undetermined
IRs AND OUTPUTS	
• **IRI 9** Public release of key performance indicators for public hospitals on a quarterly basis (Baseline: 2; Target: 14)	133%

[59] https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/decreto-64-de-2020.pdf

Exceeded: A total of 18quarterly reports on the PI for public hospitals were published as of March 2024 (equivalent to 133 percent level of achievement with respect to target of 14).	
• **IRI 10** Roll out of pilot for pre-judicial agreements to new departments Not Achieved: This activity could not be implemented, due largely to delays resulting from the COVID-19 pandemic. However, the MSPS has developed a technical document as a guide for the implementation of "Health Management Offices" in the departments, based on successful experience in Manizales, in the department of Caldas. According to reports, this experience resulted in a 76 percent reduction in the number of complaints presented to the courts.	Not Achieved
• **IRI 13** Percentage of citizen consultations and claims submitted through the internet site of the MSPS solved on time (Baseline: 80; Target: 87) Not Achieved: The percentage of consultations and claims solved on time increased from 80 percent in 2020 to 88.7 percent in 2023 but declined significantly to 72 percent in 2024. When analyzed in absolute terms, the number of consultations and claims solved on time increased from 22,805 to 29,455 (i.e., 29 percent increase) between 2019 and 2024. This increase, however, was offset by the significant increase in the absolute number of consultations and claims during the same period, from 27,233 to 42,182 (i.e., 55 percent increase), reflecting among others the high level of uncertainty among the public regarding the potential impact of the proposed health reform.	Not Achieved

Rating of Overall Efficacy

Rating: Substantial (Periods 1 & 2)

53. **The Program's achievements in improving the quality of health care services are deemed Substantial for both periods.** New certification standards and technical support provided to IPSs, including low-complexity hospitals, aimed to improve the quality of health care services at the system level (DLI 1). While no direct attribution can be established, they likely contributed to the increase in patient satisfaction between 2019 and 2023. Likewise, the newly implemented *ex-post* incentives introduced the right signals to EPSs to improve the quality of cancer care (DLI 2), likely to be a determinant factor contributing to the improved quality of breast cancer care (including screening, diagnosis and early detection) during the Program's lifetime. Even though performance for PDOI 1 was well below the anticipated target during Period 1, additional evidence points to striking achievements when compared against global cancer indicators and in the context of the COVID-19 pandemic. Finally, the affiliation of migrants to the SGSSS also had significant implications in terms of quality of services. In addition to expanding access to health care services for the migrant population, their affiliation helped prevent the likely collapse of emergency services in areas bordering Venezuela, negatively affecting the host population.

54. **The Program's achievements toward improving the efficiency of Colombia's health system are deemed Substantial.** Particularly noteworthy was the progress made toward managing pharmaceutical spending through the regulation of drug prices (DLI 3), resulting in COP 1,368 billion in estimated cost savings over the 2020-2023 period. In addition, these measures have resulted in greater access to medication, which in turn is expected to reduce morbidity and early mortality and the corresponding savings in medical care and avoided losses in productivity. Finally, as August 2020 260,721 Venezuelan migrants were enrolled in the SGSSS with the Program's support (DLI 4), which is expected to reduce the demand for emergency services and limit negative public health externalities, such as the preventable spread of infectious diseases, such as measles and HIV.

55. **This ICR does not take into consideration PDOI 2 (i.e., PI for public hospitals) for the Program's efficacy assessment of PDO 2 given its lack of significant validity.**

C. JUSTIFICATION OF OVERALL OUTCOME RATING

Rating: Moderately Satisfactory

56. **Although the Program's relevance and efficacy are deemed Substantial, its overall performance is deemed Moderately Satisfactory to reflect the delays in revising the RF (PDOI 1) and the limited validity of PDOI 2.** The methodology underlying the Program's overall outcome rating based on the split evaluation methodology is shown on Table 10.

Table 10. Overall Outcome Rating

SPLIT EVALUATION		
Restructurings with Structural Changes	**Period 1**	**Period 2**
Cumulative Disbursements (US$)	154.4	187.6
Disbursements during the period (US$)	154.4	33.2
Share of Total Disbursements (%)	82.3%	17.7%
Implementation Period	Effectiveness to Dec. 20, 2024	Dec. 20, 2024, to Closing
ASSESSMENT BY PERIOD		
1 - Relevance	**Substantial**	
2 - Efficacy	**Rating for each Period**	
PDO 1 - To improve the quality of health care services	S	S
PDO 2 - Improvements in the efficiency of the health care system	S	S
OUTCOME RATING BY PERIOD	**S**	**S**
Numerical Score *	**5**	**5**
OVERALL ASSESSMENT		
Relative Weight	82.3%	17.7%
Weighted Score	4.12	0.88
Overall Score	5.00	
Overall Rating According to Score	**Satisfactory**	
Overall Rating Reflecting Other Aspects	**Moderately Satisfactory**	

***** Highly Unsatisfactory (1); Unsatisfactory (2); Moderately Unsatisfactory (3); Moderately Satisfactory (4); Satisfactory (5); Highly Satisfactory (6)
Note: Disbursements under Period 2 are still pending contingent on the presentation of external validation by the DNP.

D. OTHER OUTCOMES AND IMPACTS

Gender

57. **The Program directly supported the GoC's strategic efforts to improve women's health and reduce gender gaps in access to effective health services.** It did so by focusing on breast cancer, which is the most important cause of avoidable mortality in women. It also supported the MSPS's efforts to address GBV by strengthening the capacity of selected municipalities to prevent, address and protect women against GBV, by, among others, implementing an intersectoral mechanism to respond to GBV and providing training to health and social services professionals to protect the privacy of female victims of GBV and inform them about their rights to pursue legal action. The percentage of municipalities with an intersectoral mechanism to respond to GBV in place (**IRI 7**) increased from 55 percent to 70.71 percent between 2019 and 2022, in line with the 70-percent target.

Institutional Strengthening

58. **As described above under Efficacy, the Program's significant contribution toward improvements in the quality of health care services and the overall efficiency of the health system.** In addition, it should be noted that, while the PI of public hospitals had limited validity at the PDO level, its inclusion in the RF (also under **IRI 9**) contributed toward its institutionalization. Specifically, since its first publication in June 2018, the PI has tracked the public-health performance of all territorial entities as well as the quality and financial performance of 931 public hospitals in 794 municipalities across the country. While additional methodological tuning up is still needed, the PI is an important tool to enhance accountability and transparency at the hospital level; thus, it is in itself a contribution toward improving the overall efficiency of the health system. The MSPS is currently revising the underlying methodology and intends to utilize it as originally intended to track the effectiveness of interventions aimed at strengthening the performance of public hospitals and to link PI improvements to incentives.

Poverty Reduction and Shared Prosperity

59. **The Program is expected to have a significant indirect impact on poverty reduction.** Improvements in the quality of health care services, both at the system level and for breast cancer, can be expected to result in improved health outcomes (i.e., reduced morbidity and early mortality), avoiding losses in productivity for the population as a whole, including the most vulnerable population groups, such as those living in poverty and in rural areas. According to the Quality of Life Survey, the gap in health insurance coverage between urban and rural areas has practically closed, with 95 percent and 93 percent coverage in rural and urban areas, respectively, in 2021.[60] Likewise, the gap in health insurance coverage by income groups has also narrowed significantly, with 91 percent and 97 percent coverage in 2021 among those in the lowest and top quintiles, respectively. In terms of quality of medical services, perceptions are similar between urban and rural areas, with 89 percent considering it to be "good" or "very good" in both cases in 2021. The perception of the quality of medical services was also similar across income levels, with 89 percent and 88 percent of those in the lowest and highest quintiles, respectively, considering it to be "good" or" very good" in 2021. In terms of quality of hospitalization services, with 93 percent of users requiring hospitalization considered the quality to be "good" or "very good" in both rural and urban areas in 2021. The perception of the quality of hospitalization services was also similar across income levels, with 93 percent and 94 percent of those in the lowest and highest quintiles, respectively, considering it to be "good" or" very good" in 2021. The impact on poverty reduction is likely particularly important for the Venezuelan migrants that gained access to health coverage under the Program, as they tend to be highly vulnerable and with a large burden of disease given the dire social and economic situation in Venezuela and the deterioration of its health system.[61]

60. **The Program's support for measures to improve the efficiency of the health care system, and, thus, its sustainability, is also expected to have a significant impact in poverty reduction and inequality.** According to research on this topic, health spending was attributed to 4.6 p.p. in poverty reduction in 2020. Likewise, regarding inequality, health spending contributed to a decrease of approximately 0.0261 points in the Gini coefficient in 2020.[62]

III. KEY FACTORS AFFECTED IMPLEMENTATION AND OUTCOME

A. KEY FACTORS DURING PREPARATION

61. **The Program benefited from a strong technical design.** One of the strengths was the appropriateness of the lending instrument, as the PforR instrument lent itself well to support the implementation of the priorities in the health sector under the 2018-2022 PND, providing financial incentives for the achievement of tangible results that reflected the

[60] Nuñez, J. (2023), *Logros en equidad del sistema de salud y la reforma en Colombia*, June 2023, Fedesarrollo, Bogotá, Colombia. [https://www.repository.fedesarrollo.org.co/bitstream/handle/11445/4434/Report_Junio_2023_Núñez_et_al.pdf?sequence=5&isAllowed=y]
[61] Nuñez (2023).
[62] Nuñez (2023).

stewardship role of the MSPS. It should be noted that this PforR was the first lending operation that the WB had had in Colombia's health sector in more than 25 years. It was also the first time that the PforR instrument was utilized in Colombia. The Program also built on a multi-year analytical engagement with the GoC on issues related to the financial sustainability, quality, and efficiency of the health sector, which provided a sound evidence-based foundation for technical design.[63] The Program also helped coordinate and maximize synergies with other investments and technical assistance provided by the IDB as well as support under the GCFF Trust Fund. The latter one provided not only financial support but also implicit recognition to the significant efforts by the GoC to provide access to health care services to the large numbers of migrants from Venezuela. Other strengths included the preparation of a robust *ex-ante* economic analysis, a Program Action Plan (PAP) to strengthen the country's social, environmental, and fiduciary systems, a realistic risk assessment, and the incorporation of the lessons learned from other PforR operations in the region, including Costa Rica's Strengthening Universal Health Insurance Program (P148435).

62. **Despite an overall technically sound design, there were weaknesses in the RF.** Two of the three PDOIs (PDOI 1 – Early detection of breast cancer; and PDOI 3 – Cost reductions in pharmaceutical purchases) reflected GoC's top priorities as illustrated by their inclusion in the 2018-2022 PND and were fully aligned with the actions supported under the Program. Conversely, while PDOI 2 (PI of public hospitals) was an important priority for health sector authorities, it was only partially aligned with the actions supported under the Program. Specifically, the PI was introduced in June 2018 as part of the government's Integrated Action Program for Public Hospitals (*Programa Acción Integral en Hospitales Públicos* – ai), which sought to improve the performance of public hospitals through, among others, enhanced regulatory instruments such as the ones under RA 1, TA, improvements in hospital infrastructure and medical equipment, strengthening of information systems, and the piloting of incentives. In this context, the PI served two purposes: (i) to provide objective evidence to track improvements in performance; and (ii) to enhance accountability and transparency. Despite its strategic importance, the PI lacked enough validity to be included as an indicator at the PDO level, as only 8 of the 24 sub-indicators focused on one of the areas of Program support (i.e., quality of health care services). Of the remaining 16 sub-indicators, seven focused on public health at the territorial entity level and nine sub-indicators on the financial soundness of public hospitals. Therefore, 16 out of 24 sub-indicators were not directly related to the actions supported under the Program; thus, undermining the PI's validity as an outcome indicator. On the other hand, including the continuous public dissemination of PI results at the IRI level (IRI 9) was amply justified to give it visibility and support ifs sustainability.

B. KEY FACTORS DURING IMPLEMENTATION

Factors Outside the Government's Control

63. **COVID-19 pandemic.** Approved just two days after the World Health Organization declared COVID-19 a global pandemic, the Program was deeply impacted by it on two fronts. First, it affected the implementation of individual activities, such as those heavily reliant on human interactions (e.g., the implementation of a pilot on pre-judicial agreements). Second, it affected the achievement of targets related to the provision of services, specifically breast cancer detection (i.e., PDOI 1 and IRI 2). In countries around the world, including Colombia, the COVID-19 pandemic resulted in

[63] This work included: the development of the Atlas of Geographic Variations in Health; the support to increase tobacco taxes; the study of multi-morbidities in Colombia; the assessment of the impact of migration in Colombia and response strategies; the technical assistance to strengthen the governance and financial management of the health system (with South Korea); the technical assistance in issues related to the judicialization of health (through the WB's Collaborative Learning Initiative on the Right Health and Universal Health Care, "*SaluDerecho*"); and the three-phase Reimbursable Advisory Services (RAS) to support the National Health Superintendence in the development of a risk-based supervision model.

interruptions in the provision of PHC services, disruptions to regular hospital level services, a sharp decline in the demand for services due to fear of contagion and mobility restrictions, and changes in lifestyle and psychological wellbeing. As of the end of 2021, 93 percent of countries in the Latin America and the Caribbean region reported interruptions in provision of essential health services for all modalities, with 26 percent of them reporting interruptions of 75 to 100 percent of the services, and with average interruptions in 55 percent of the 66 services analyzed.[64] As discussed earlier, the COVID-19 pandemic had a lesser impact on the delivery of care for breast cancer, with the number of new breast cancer cases dropping by only 6.4 percent between 2019 and 2020, and rapidly bouncing back in 2021, exceeding the pre-pandemic values. As mentioned earlier as part of the discussion on the Program's efficacy, the actions implemented by the MSPS to combat cancer with the support of this Program are expected to have played a determinant role in ameliorating the impact of the pandemic on cancer care. In addition, as reported by the MSPS staff, Resolution N. 3100/2019 that updated certification standards for IPSs (DLI 1.1) also had an important positive impact in the context of the COVID-19 pandemic, as it established standards for telemedicine and intramural provision of services that proved critical for continuing the provision of health services during the health emergency. The updated certification standards also put particular emphasis on the control of secondary risks, greatly facilitating the conversion of emergency care beds into intensive care and isolation facilities.

64. **Need for complementary TA.** While the Program provided financial incentives to achieve the agreed results, some of the actions of support were complex to design and implement. While not highly visible, a substantial amount of TA by the WB and other development partners went hand-in-hand with the financial support provided under this PforR. The high percentage of MSPS staff under contract – about 40 percent – and its high turnover, contributed to the need for additional support. To this effect, a four-year international senior health specialist position was added in the WB's Colombia country office to provide implementation support to the PforR and related engagement in the health sector. While the Team was very proactive in securing additional funds for complementary TA, it is advisable to assess the need for TA that may arise from PforR implementation at the design phase and identify potential financing sources from the beginning.

65. **Impact on the WB's portfolio.** The PforR instrument - used for the first time in Colombia – proved to be an effective instrument to reengage in Colombia's health sector. In addition, building upon the positive experience and implementation capacity developed under this program, other health sector PforRs have followed, including the ongoing Program for Improved Access to Effective Health Services for the Vulnerable and Enhanced Health System Resilience.[65]

Factors Inside the Government's Control

66. **Alignment (or the lack of it) with political cycles.** As originally conceived, this Program was in full alignment with the 2018-2022 PND in terms of the development objectives, supported policy actions, and implementation timetable (2020-2022). However, progress toward the achievement of DLI milestones was slower than anticipated, in large part due to the COVID-19 pandemic. As of June 2022, 18 months after its effectiveness and two months before the original closing date, the Program had disbursed US$126 million (i.e., 67.4 percent disbursement rate) after achieving eight out of 12

[64] PAHO: https://hia.paho.org/en/covid-2022/health

[65] Colombia's Program for Improved Access to Effective Health Services for the Vulnerable and Enhanced Health System Resilience (P180534) was approved on February 13, 2024, for US$304.5 million.

original DLI milestones.[66] While three out of four pending milestones were expected to be achieved before the end of the 2018-2022 presidential administration (August 2022), it was clear that PDOI 1/DLI 2.3 was not going to be achieved (i.e., percentage of breast cancer cases detected early). The WB Task Team put in place TA to analyze the situation in detail in coordination with its MSPS counterparts, the Organisation for Economic Co-operation and Development (OECD) and other international partners. However, given the ongoing challenges posed by the COVID-19 pandemic and the election of a new government on June 19, 2022, the decision was made to send a managerial letter to the new government with a proposal for an extension of the Program's closing date and a subsequent restructuring of the Program to address challenges related to the DLI on early detection of breast cancer.

67. **Implementation bottlenecks.** After taking office in August 2022, the current administration moved swiftly on an ambitious reform agenda, including presenting to Congress a proposal to restructure the country's health sector (see Section – Relevance). However, uncertainty regarding the approval of the proposed health reform – still pending approval by Congress – contributed to the significant delays in the approval of the third restructuring to adjust the adjust the RF and some of the DLIs. Technical discussions on the third restructuring between the Bank and the MSPS started in May 2023, and the GoC's formal request was received on October 11, 2024, and the resulting amendment to the corresponding FA was only signed on December 20, 2024, just ten days before the Program's scheduled closing date. Other factors contributing to the delay were lengthy approval process on the client's side as well as the MSPS' limited institutional capacity due to its heavy reliance on contracted personnel that tends to change with each administration. These factors affect the entire Bank's portfolio in Colombia.

68. **Value added of this Program.** The PforR instrument proved effective in maintaining a focus on medium and long-term development goals, even amid the urgent demands of the pandemic response and the changes associated with the health reform proposed by a new government administration. Despite their marked differences in political orientation, the MSPS leadership from both the previous and current administrations demonstrated a strong commitment to the development objectives supported by the Program, with the own priorities of the latter reflected in the modifications introduced under the third restructuring.

IV. BANK PERFORMANCE, COMPLIANCE ISSUES, AND RISK TO DEVELOPMENT OUTCOME

A. QUALITY OF MONITORING AND EVALUATION (M&E)

M&E Design

69. The Program's RF included three PDOIs, two of which (PDOIs 1 and 3) were also featured in the 2018–2022 PND, underscoring their strategic importance to the GoC. These two indicators were closely aligned with the Program's areas of support and, together with a robust set of IRIs, played a key role in tracking implementation progress and achievement of the PDOs. Conversely, despite having strategic importance, the third PDOI indicator (PDOI 2) was only loosely aligned with the Program's areas of support; thus, it had limited validity. Disbursements were tied to a set of DLIs with clearly defined operational definitions, targets, and verification protocols. DLIs included a balanced mix of easier-to-achieve targets (e.g., prior results), more ambitious results, and even stretch goals, helping maintain momentum and focus

[66] The Program disbursed in record time after effectiveness, with US$99 million disbursed in 2020 linked to the three previous results (DLIs) as well as the achievement of four additional DLI milestones. During 2021, three additional DLI milestones were met, amounting to US$27.4 million in disbursements.

throughout implementation. Both the RF and the DLIs reflected the stewardship role of the MSPS, showcasing the Ministry's use of policy instruments—legislation, policy, and regulation—to influence insurance and service delivery functions, rather than relying on direct control.

70. M&E data was provided by reliable internal and public sources. Data for quantitative indicators was obtained from several databases, including information from healthcare providers and insurers collected by the High-Cost Account (*Cuenta de Alto Costo*, CAC), the Social Protection Integrated Information System (*Sistema Integrado de Información de la Protección Social,* SISPRO), as well as other administrative data sources. Regulatory actions were monitored and verified using the Official Journal of the Republic of Colombia, which publishes legal acts and public notices of the President, Congress, and government agencies.

M&E Implementation

71. The M&E system adequately supported both disbursements and monitoring of the Program's implementation. Specifically, DLIs facilitated the disbursement of funds once targets were met and externally verified by the DNP in accordance with predefined protocols. Although the RF was not formally revised until near the end of the Program due to delays on the client's side, it still served as a useful tool for tracking implementation progress. This was made possible by leveraging Colombia's robust information systems, including cancer statistics produced by the CAC.

72. Two sets of changes were introduced to the RF during the third restructuring. First, adjustments were made to the DLIs and IRIs to align the Program with the priorities of the current administration. While these changes were formally approved on December 20, 2024, they had already been agreed upon in May 2023 and monitored accordingly. Second, modifications were made to both the baseline and end target of PDOI 1 (Percentage of women with breast cancer detected at an early stage). The original baseline, based on 2018 data—the latest available at the time of preparation—was updated to 2019 data to reflect performance more accurately prior to Program implementation. Additionally, the end target for PDOI 1, originally aligned with the 2018–2022 PND, required a downward revision to account for the lower baseline and the adverse impact of the COVID-19 pandemic on health service demand.

M&E Utilization

73. The Program's M&E system adequately supported the Program's evaluation and performance assessment. The RF served to monitor implementation progress as well as PDO achievement. Externally verified DLIs supported disbursement in a sound and transparent manner. Particularly noteworthy was the rigorous analysis and reporting of cancer data by the CAC, which served as a key input in the assessment of PDO 1 under this ICR. However, these data are subject to a significant reporting lag of 16 to 18 months. This delay is due not only to the time required for data reporting and aggregation but also to a two-stage auditing process: first, external auditors verify the clinical data submitted by service providers; second, the MSPS validates the accuracy of the information provided by the CAC, including patient identity and health coverage. As a result, the extended timeline limited the usefulness of this data for timely programmatic adjustments.

74. The Program contributed to further strengthening the Borrower's own M&E systems, including the National Cancer Information System (NCIS)[67] and the Unified Database of Affiliation (*Base de Datos Única de Afiliados,* BDUA).

- *NCIS:* The newly implemented *ex-post* risk adjustment mechanism supported by the Program has contributed to better and more reporting on the part of health care providers, resulting in a significant expansion of the nominalized clinical registry of cancer patients administered by the CAC. The improvement is illustrated by the rapid increase in the number of newly reported cancer cases from 2019 onward (see Annex 5, Figure 5.1). Given its national coverage, the use of a clearly defined methodology and the quality of externally audited data, this registry provides highly valuable information not just for the administration of the *ex-post* adjustment mechanism but for public health policy decision making. As noted earlier, however, it would be important to reduce the reporting lag time, which can be expected to negatively impact financial incentives, particularly in an inflationary context.
- *BDUA:* The PAP implemented a part of the Program also contributed to the strengthening of the BDUA, which provides a unique identifier for each individual affiliated to the SGSSS. Primarily aimed to avoid double counting between this Program and the IBD operation, both of which supported the affiliation of regularly registered Venezuelan migrants to the SGSSS, the actions implemented under the Improvement Plan focused on identifying, correcting, and removing errors, inconsistencies, and redundancies within a database to ensure data quality and integrity. As a result, there were significant improvements between 2019 and 2024, including: (i) the elimination of all beneficiaries in the contributory regime without association with a contributor, and beneficiaries in the subsidized regime without association with a head of household (7,636 beneficiaries in 2019); (ii) the elimination of all deceased beneficiaries (322 in 2019); (iii) 80 percent reduction in the number of records with identification documents that do not correspond to their age range (from 60,737 to 11,859); (iv) the elimination of all duplications (62,192 in 2019); (v) a 93 percent reduction in the number of records whose documents do not correspond to current regulatory guidelines (from 15,636 to 1,163); (vi) the elimination of records with affiliations to more than one regime (from 27,553 to 32); and (vii) the elimination of records with pension allocation and active status in the subsidized regime (from 4,168 to 1).

Justification of Overall Rating of Quality of M&E

Rating: Substantial

75. The quality of the Program's M&E system is deemed Substantial. The RF was well-structured, with two sound PDO-level indicators and a robust set of intermediate indicators. Disbursements were linked to DLIs with clearly defined targets and verification protocols. M&E data were drawn from reliable administrative sources and used to support implementation monitoring, disbursement, and evaluation. The Program also contributed to strengthening national systems such as the NCIS and the BDUA. Moderate shortcomings affecting overall effectiveness included delays in restructuring key indicators and a lengthy reporting lag for cancer data, which constrained its use for more timely adjustments. The limitations in the validity of the PI (PDOI 2), which hindered attribution, is considered a weakness in the Program's quality at entry.

[67] Established in 2012 together with the National Cancer Observatory by MSPS's Resolution No. 4496/2012. [https://www.infocancer.co/portal/#!/home]

B. ENVIRONMENTAL, SOCIAL, AND FIDUCIARY COMPLIANCE

Environmental and Social Compliance

76. The Program was implemented in accordance with the WB's PforR Financing Policy. The Environmental and Social Systems Assessment (ESSA) assessed environmental and social risks as low and identified minor deficiencies. To address these gaps, ESSA presented a PAP comprised of two environmental and three social Action Programs (APs), which can be summarized as follows: (See Annex 5 for additional information.)

- *AP 1.* The result of Action 1 was Resolution 591/2024, which approved the update of the Comprehensive Sanitary Waste Management Manual and the training of environmental health technicians, professionals, coordinators, and representatives for its implementation.
- *AP 2.* The outcome of Action 2 was Resolution 367 of 2023, which establishes the process for strengthening environmental health management at the territorial level. The guided document for the classification and reporting of hazardous waste generated in healthcare and other similar activities was developed, allowing the Ministries of Environment and Health to update their hazardous waste policy and action plan through 2030. All these processes contribute to strengthening the Single Environmental Health Information System (*Sistema Unificado de Información en Salud Ambiental*, SUISA).
- *AP 3.* Between 2022 and 2024, working groups were held with the Indigenous Health Subcommittee of the Permanent Consultation Round Table, and territorial meetings were held to adapt the health guidelines. Agreements were signed with nine indigenous organizations for the territorial dissemination of guidelines of the Intercultural Indigenous Health System (SISPI). The final validation of the document took place at the National Indigenous Congress in October 2024, which represents the different indigenous peoples of Colombia. This document is expected to be signed by the President at the end of 2025.
- *AP 4.* Between 2022 and 2024, the MPSP, the National Space for Prior Consultation and 34 *kilombos* (ethnic organizations) representing the Black, Afro-Colombian, Raizal and Palenquero (*Negro, Afrocolombiano, Raizal y Palenquero,* NARP) community agreed on a health technical document. In 2023, an agreement was signed with an Ethnic Council for the national dissemination of this document, which was adopted by MPSP Resolution 1964 of 2024. Similarly, during 2022, workshops were held with the authorities of the Rom people to construct and agree on the health guidelines. In 2023, consultations were carried out on draft law 339 of 2023 (reform of the health system) to ensure the inclusion of the Rom guidelines. At the end of 2024, the result of the consultation process was the preliminary document "Health policy guidelines with a differential approach for Roma people within the framework of the general health system." A final version is expected to be ready by the end of 2025 in order to prepare an administrative act. The actions carried out in the social PAP contributed to closing the social gaps identified in the health system in relation to access and culturally appropriate provision of health services for ethnic groups. No commitments were identified after the closing of the PAP. The MSPS has made the commitment to continue with the approval and implementation of the health guidelines for ethnic groups.

Fiduciary Performance

77. **The fiduciary framework was deemed adequate to support the implementation of the PforR Program**. The Financial Management (FM) performance was rated as satisfactory, and fiduciary risks were assessed as moderate during the implementation phase. Existing FM systems effectively facilitated budget planning and execution, fund flow processes, transaction recording, and the generation of financial reports. Although minor shortcomings in FM were identified, they did not impede the timely and reliable provision of information necessary for managing and monitoring program

implementation. Semi-annual financial reports were submitted satisfactorily, with a focus on the Program's budget execution. The Office of the Comptroller General of the Republic *(Contraloría General de la República,* CGR) reported the annual audited financial statements in accordance with the provisions established in the Memorandum of Collaboration signed between the CGR and the WB for this program. This memorandum requires the submission of the annual audit report no later than seven months after the end of the audited fiscal year. The CGR adhered to this requirement. As of the date of this report, the audit for the 2024 fiscal year is in progress, with the report expected to be submitted by July 30, 2025.

78. **The fiduciary PAP was satisfactorily implemented throughout the Program's execution.** The MSPS and the ADRES periodically followed up on the improvement plans presented to the CGR. The Program's budget allocation process was monitored in collaboration with the Ministry of Finance to ensure the availability of the required budget. As part of the audit process, the CGR informed the WB about fraud and corruption reports and complaints handling. During supervision missions, the MSPS and ADRES reported that there was no evidence of fraud and corruption risks materializing within the Program, as reflected in the entity's reports.

C. BANK PERFORMANCE

Quality at Entry

Rating: Moderately Satisfactory

79. **The Program benefited from a sound technical design, drawing on the WB's recent analytical work in Colombia's health sector**. The choice of lending instrument was appropriate, as the PforR aligned well with the results-oriented 2018–2022 PND. The Program's technical design and overall readiness were strong—both at the overall level and for its individual components. The DLIs were relevant and supported by well-defined operational criteria and robust verification procedures. Although the Program supported a wide range of actions, risk assessments were realistic, and key technical risks were addressed through a well-prepared PAP. Coordination with the IDB operation was effective, and synergies were achieved with technical assistance from other development partners, including the Dutch Embassy.

80. **In retrospect, however, the scope of the PforR may have been overly ambitious.** A large number of actions included in the RF were not directly linked to DLIs and required extensive monitoring due to their complexity. The composite PI for public hospitals (PDOI 2), in particular, did not adequately reflect the impact of the Program's interventions. Nonetheless, its inclusion was consistent with the Government's strategic priorities and aligned with related activities that were implemented by the GoC but not explicitly supported under the Program. In addition, the indicator's recent introduction, along with initial delays in reporting, masked its methodological weaknesses, including its cyclical nature. Therefore, while the inclusion of the PI for public hospitals as an outcome indicator represents a design weakness, it is considered moderate within the context of an otherwise robust technical framework.

Quality of Supervision

Rating: Highly Satisfactory

81. **The quality of supervision was highly satisfactory**. Regular missions ensured continuous engagement with the MSPS units responsible for implementing various actions. Findings were systematically documented in detailed Aide Memoires and Implementation Status and Results Reports (ISRs). The Program benefited from a strong and stable Task Team, with smooth transitions between successive Task Team Leaders (TTLs). TTLs were highly experienced, and the local presence of one of them was critical for the close and ongoing follow-up to ensure needed actions on part of the government. The WB Team provided ongoing technical support, including the implementation of the Program Action Plan on social, environmental, and fiduciary safeguards. Additionally, they offered expert guidance on substantive areas, facilitating access to specialists from the WB and other countries to aid in designing and implementing complex strategic reforms.[68] To further support Program-related activities beyond the PforR instrument's scope, the WB Team actively secured additional funding, obtaining an annual average of US$1 million in trust funds and bank budget (excluding staff time). The combination of targeted technical assistance and financial incentives played a crucial role in overcoming technical challenges and advancing key reforms to achieve the Program's objectives.

82. **It is important to underscore that the need to restructure the Program to modify one of the outcome indicators (PDOI 1) was identified before the Mid-term Review, which took place in April 2022.** Similarly, the need to adjust the Program to the priorities of the new administration was identified in 2023. The delays in requesting the third restructuring were partly due to uncertainty regarding the approval of the proposed health reform and, once requested, the delays in its approval were due to a lengthy approval process on the client's side. The WB Team deserves much credit for its persistent efforts to obtain the final signature of this restructuring.

83. **The WB exhibited great flexibility, restructuring the Program three times to ensure it reflected current policy priorities in the health sector and a realistic implementation timeframe.** The close engagement of the WB's Division Director was critical to overcome bureaucratic delays affecting the third restructuring by conveying their importance to the highest authorities, both within the MSPS and the Ministry of Finance.

Justification of Overall Rating of Bank Performance

Rating: Satisfactory

84. **Overall WB performance is deemed satisfactory to reflect its moderately satisfactory performance in ensuring quality at entry and highly satisfactory supervision.**

D. RISK TO DEVELOPMENT OUTCOME

Rating: Substantial

85. **The risk to the sustainability of the Program's outcomes is deemed Substantial.** The political environment continues to be highly uncertain, and the potential legislative changes could drastically restructure the health system.

[68] Some examples of complementary TA support include, among others: (i) updating of quality standards in healthcare and development of technical documents to support deployment at the healthcare provider level; (ii) harmonization of quality aspects related to primary healthcare, telehealth, and telemedicine; (iii) multimorbidity study to support the design of UPS risk adjustment; (iv) workshops with international experts to identify international best practices for early detection of breast cancer.

While policies that have proven to be effective, like the implementation of *ex-post,* performance-based financial incentives to enhance the quality of cancer care, they would require to be fully redesigned to respond to a new organizational framework. Another area of concern for the Colombia's portfolio as a whole is the limited in-house technical capacity of the MSPS, which relies heavily of contracted staff. The fact that a follow-up operation is ongoing ensures the continuation of the dialogue between the WB and the GoC.[69] The ongoing PforR also complements actions supported under this Program, such as the certification of healthcare providers and quality of care and expanding access to health services among eligible migrants.

[69] World Bank (2024), *Colombia - Program for Improved Access to Effective Health Services for the Vulnerable and Enhanced Health System Resilience,* Washington, D.C.: World Bank. Group.
[http://documents.worldbank.org/curated/en/099012224124520218/BOSIB1a3c37f2e0a3180ce10dd4d63874c7]

V. LESSONS AND RECOMMENDATIONS

86. **The following lessons can be derived from the implementation experience and results of this PforR:**

87. **Effectiveness of the PforR instrument.** This operation underscores the effectiveness of the PforR instrument in supporting sector programs with an emphasis on reform. The key advantages are enhanced focus on results, further strengthening of country systems and processes, and lower risks to development outcomes.

88. **Design of DLIs.** DLIs should ideally include a balanced mix of easier-to-achieve targets (e.g., prior results), more ambitious results, and even stretch goals. The timing and sequencing of these results are critical to maintaining momentum and focus throughout implementation. The initial design of the operation effectively supported this approach, helping to build early momentum and gradually advance toward the achievement of increasingly complex results, thereby reinforcing the Program's strategic relevance.

89. **Demand for TA under PforRs.** An important lesson derived from this PforR is the need for TA to support specific reforms, particularly those with specific know-how. In the case of Colombia, the need for complementary TA is compounded by the high proportion of MSPS staff that is under contract and their high turn-over. Some relevant takeaways can be derived from this particular experience: (i) there is an expectation on the part of the Borrower that they can count on TA from the WB, particularly as this is one of the institution's competitive advantages; (ii) when the need for TA arises in the context of PforR operations, the burden to obtain the necessary funding falls on the WB Task Team; and (iii) the process of obtaining such financial support is not only time consuming but also uncertain in terms of its eventual success. Had the Team not been successful in obtaining *ad-hoc* financial support required for this TA, the Program's implementation could have been compromised.

90. **Strong supervision and continuous engagement.** The ongoing engagement of the Task Team with its MSPS counterparts on technical and implementation issues was critical for the Program's success. Equally important was the close support of the CMU, as well as the ongoing dialogue with MSPS authorities and those of other ministries on critical policy issues and bureaucratic bottlenecks. This close engagement was particularly important after the change in administration and the proposed health reform, which reflects a significant reorganization of the health sector.

91. **Scope and timeframe of PforR operations.** As originally conceived, this Program was in full alignment with the 2018-2022 PND in terms of its development objectives, the policy actions being supported, and the implementation timetable (i.e., with a closing date of March 2022). This alignment, however, was significantly weakened after the 2022 presidential elections, as the new administration's vision for the health sector was significantly different from the one reflected under the PforR. This was reflected in the Program's relatively fast disbursements during the previous presidential cycle, equivalent to 67.4 percent of total disbursements over 21 months[70] vis-à-vis 14.9 percent during the current one over 27 months, with 17.7 percent of total disbursements still pending at closing. At the same time, preparing a new PforR takes time, particularly after a change in administration, as well as the implementation of any significant policy action. These challenges are exacerbated in countries with shorter presidential administrations, such as a four-year presidential term in many countries, including Colombia. These two factors seem to point to the need to design more compact PforR operations that focus more narrowly on key policy actions that have strongest political support.

92. **Strategic use of incentives.** Linking disbursements to results in PforR operations encourages performance-driven implementation, as well-designed incentives help overcome technical and institutional barriers, driving progress toward key development objectives. In the case of this Program, the effectiveness of performance-based financial incentives was also exhibited in the case of the new risk adjustment methodology adopted for cancer care. If approved, it would be

[70] From effectiveness (November 30, 2020) to end of August 2022.

important to adapt this type of mechanism to the new structure of the health sector being proposed under the still pending health reform sustain the achievements in improved access and quality of cancer care, breast cancer in particular.

93. **Compound indicators.** As highlighted in this PforR, the use of broad compound indicators such as the PI for public hospitals may pose challenges in terms of attribution. Nevertheless, the continuous implementation of the PI has brought significant transparency and accountability to the performance of public hospitals.

94. **Environmental aspects.** The compilation and systematization of information on the generation and management of health care waste served to update the regulations and operating procedures (technical manuals). In addition, it was linked to environmental management monitoring processes in health service providers, allowing for alternative training interventions.

ANNEX 1. RESULTS FRAMEWORK, DISBURSEMENT LINKED INDICATORS, AND PROGRAM ACTION PLAN

A. RESULTS FRAMEWORK

PDO Indicators by PDO Outcomes

Quality								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Percentage of women with breast cancer detected in early stage (IIA) (PND) (Percentage)	49.86	Dec/2019			55.00	Dec/2022	55.95	Dec/2023
	Comments on achieving targets		This indicator was included in the restructuring signed by the Minister of Finance on December 20, 2024. The two adjustments include (i) replacing the overestimated baseline level with the actual 2019 figure (49.86 percent) and (ii) lowering the PDO1 target to 55 percent (down from 69 percent). The value for 2023 is preliminary based on audited data reported by EPS to the CCA. The official statistic, which is not expected to change significantly, will be released in May-June 2025 after verification by the MSPS.						
Efficiency								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Performance Index for public hospitals (Ai Hospitals) (Percentage)	61.00	Jul/2019			70.00	Dec/2022	75.88	Dec/2023
	Comments on achieving targets		Information for 2024 is still under revision. End target achievement. Undetermined. As detailed in Annex 5, the target for PDOI 2 can be interpreted as either achieved or not achieved depending on the measurement approach, given the indicator's high intra-annual variability.					
Efficieny gains achieved over the period 2020 - 2022 with new regulations in the pharmaceutical market (Text)	0.00	Jul/2019			800,000,000	Dec/2022	COP 946 billion	Dec/2022
	Comments on achieving targets		COP 800 billion Achieved (Disbursement #1, Dec. 2020). Measurement reported for 2022 comes from the DNP's evaluation of the 2018-2022 PND.					

Intermediate Results Indicators by Result Areas

QUALITY								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
People receiving quality health, nutrition, and population services (Number of people) CRI					0	Dec/2026	0	Dec/2026
	Comments on achieving targets		This is a new indicator and because the same population will be included in the other PfroR (P180534), the team will be tracking under that operation the CSI in order to avoid any potential for double counting across the operations.					
People receiving quality health, nutrition, and population services – Youth (Number of people) CRI					0	Dec/2026	0	Dec/2026
	Comments on achieving targets		This is a new indicator and because the same population will be included in the other PfroR (P180534), the team will be tracking under that operation the CSI in order to avoid any potential for double counting across the operations.					
People receiving quality health, nutrition, and population services – Female (Number of people) CRI					0	Dec/2026	0	Dec/2026
	Comments on achieving targets		This is a new indicator and because the same population will be included in the other PfroR (P180534), the team will be tracking under that operation the CSI in order to avoid any potential for double counting across the operations.					
Percentage of women 50 - 69 years of age screened for breast cancer according to defined protocols. (Percentage)	21.20	Dec/2018			30.00	Dec/2022	37.92	Dec/2023
	Comments on achieving targets		End target achieved					
Number of low complexity public hospitals technically assisted in the accreditation process (cumulative) (Number)	2.00	Aug/2019			60.00	Sep/2022	132.00	Nov/2023
	Comments on achieving targets		End target achieved					
Regulation for training heatlh care personnel in continous quality improvement approved (Text)	N/A	Aug/2019			Regulation Published	Sep/2022	Regulation Published	Mar/2022
	Comments on achieving targets		The government has issued Decree 376 de 2022 to implement the Continuous Training System for Human Talent in Health. Access to Decree: https://www.funcionpublica.gov.co/eva/gestornormativo/norma_pdf.php?i=184269. End target achieved.					

Interoperability (IO) standards for electronic health records developed and implemented in priority regions (Text)	No definition of minimum interoperability standards	Aug/2019			Regulation published defining minimum interoperability standards for electronic health records	Sep/2022	Resolution 866 of June 25, 2021 issued	Jun/2021
	Comments on achieving targets		Resolution 866, defining minimum interoperability standards for electronic health records, was published on June 25, 2021. End target achieved. New regulation complementing Res866 and establishing the technical implementation of the minimum summary of clinical data					
Updating regulation of use of telemedicine to improve access to quality care (Text)	NA	Dec/2019			Regulation updated	Dec/2020	Regulation Updated	Mar/2022
	Comments on achieving targets		Access to de updated regulation: https://www.minsalud.gov.co/normatividad_nuevo/resoluci%C3%B3n%20no.%202654%20del%202019.pdf. End target achieved.					
QUALITY AND GENDER GAP								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Percentage of municipalities with an intersectoral mechanism to respond to gender-based violence in place (Percentage)	55.00	Aug/2019			70.00	Sep/2022	70.71	Dec/2024
	Comments on achieving targets		The measurement has been revised as the previous reporting data includes also includes departments and territories. This indicator measures the intersectoral mechanism in municipalities. End target achieved					
EFFICIENCY								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Development of a prioritization mechanism to update the benefits plan (Text)	NA	Aug/2019			New prioritization matrix of Benefit Plan published	Sep/2022	Matrix of prioritization for benefits plan published	Jun/2021
	Comments on achieving targets		https://www.minsalud.gov.co/salud/POS/Paginas/resultados-pos.aspx End-Target achieved.					
	2 public quarterly releases	Aug/2019			14 public quarterly released	Sep/2022	18	Mar/2024

Public release of key performance indicators for public hospitals on a quarterly basis (cumulative) (Text)	Comments on achieving targets		End- target achieved.					
Roll out of pilot for pre-judicial agreements to new departments (Number)	0.00	Aug/2019			6.00	Dec/2022	0.00	Dec/2021
	Comments on achieving targets		The Roll-out of the pilot for pre-judicial agreements could not be implemented. However, the Ministry has prepared a technical document that serves as guidelines for the implementation of care offices for citizens who intend to establish constitutional actions (tutelas) in health matters, intending to allow territorial entities to know the aspects that must be considered for the adoption of the strategy. This initiative has already been successful in the Department of Caldas, Manizales, with a 76% reduction in the number of constitutional actions.					
Publication of analysis of the pharmaceutical market for the incorporation of medicines and medical devices into the probation regime (libertad vigilada y control directo) (Text)	Bulletin 1	Aug/2019			Bulletin 4	Mar/2023	Bulletin 4	Dec/2022
	Comments on achieving targets		MoH has published three additional bulletins: i. Coronary https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/MET/boletin-precios-02-dm-endovasculares-dic2021.pdf; ii. Contraceptives https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/MET/boletin-precio-03-dm-anticonceptivos-dic2021.pdf; iii. Out-of-pocket analysis https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/MET/boletin-gasto-bolsillo.pdf End-target achieved.					
MIGRATION								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Number of departments with strengthened capabilities to allow the affiliation of migrants to the SGSSS (Number)	0.00	Aug/2019			24.00	Sep/2022	24.00	Dec/2022
	Comments on achieving targets		The MSPS continues supporting the departments through technical assistance to strengthen their capacity to affiliate migrants to the health system. End- target achieved.					
CITIZEN ENGAGEMENT								
Indicator Name	Baseline		Closing Period (Original)		Closing Period (Current)		Actual Achieved at Completion	
	Result	Month/Year	Result	Month/Year	Result	Month/Year	Result	Month/Year
Percentage of citizen consultations and claims submitted through the internet site of the MSPS solved on	80.00	Aug/2019			87.00	Oct/2024	72.00	Dec/2024
	Comments on achieving targets		This measurement is preliminary. Information for 2024 is still under revision.					

time according to resolution 3687 of 2016 (PQRSD) (Percentage)		

Disbursement Linked Indicators (DLI)

Period	Period Definition
Prior Results	
Period 1	Prior Results
Period 2	September of 2020
Period 3	September of 2021
Period 4	September of 2022
Period 5	December of 2024

	Baseline	Prior Results	Period 1	Period 2	Period 3	Period 4	Period 5
1:Updated and new regulations defining the processes and standards for the certification (habilitación) and accreditation of health care providers (Text)		Achievement Level: Not Due					
Original/Revised Value	NA		Administrative act updating certification (habilitación) standards to be met by health care facilities, including standards for environmental management, published in the Official Journal of the Republic of Colombia.			Administrative act defining quality standards and simplified processes for the accreditation of low-complexity hospitals that include the introduction of environmental management standards, published in the Official Journal of	MSPS regulation (administrative act) defining quality standards for Primary Health Care Facilities, that promote environmental sustainability, has been issued and published in the Official Journal

						the Republic of Colombia	
Allocated Amount	0.00	0.00	11.72	0.00	0.00	17.59	17.59
Actual Value			Resolution 3100/2019 published			Regulation No. 1328/2021 published	Resolution No. 2696/2024 published (disbursement expected in June 2025)
Actual Amount			11.72			17.59	
2:Incentives introduced in the payment system to achieve higher quality of care and efficiency (Text)		Achievement Level: Not Due					
Original/Revised Value	49.86%			Administrative act with the new ex-post adjustment of the UPC (for breast cancer) published in the Official Journal of the Republic of Colombia	UPC risk adjustment methodology dully discussed, and resulting technical document published on the MSPS website	At time of diagnosis, 51.50% of women with breast cancer detected at stage IIA or lower has been achieved	MSPS's instructions (circular) for the strengthening of actions for cancer control in Colombia - Plan de Choque-, published in the digital institutional repository of the MSPS
Allocated Amount	0.00	0.00	0.00	15.63	15.63	2.40	13.24
Actual Value				Resolutions 3339/2019 and 1620/2020 published	Technical document published in May 2022	Target achieved (The MSPS is requesting an extension of grace period to disburse this result. Expected in August 2025)	Action plan published in July 2024 (disbursement expected in June 2025)
Actual Amount				15.63	15.63		

3:Efficiency gains in pharmaceutical expenditure as a consequence of pharmaceutical market regulatory policies (Text)		Achievement Level:					
Original/Revised Value	0		Administrative act (circular) defining the new drug price regulation methodology, published on the MSPS website for public consultation	Application of the current drug price regulation methodology (Circular 03 of 2013) to at least 50 new relevant markets	egulation (circular) defining the methodology used to control the introduction of high cost drugs in the market (regulation of the puerta de entrada), published in the Official Journal of the Republic of Colombia	Regulatory measures implemented lead to efficiency gains, measured by the difference between the regulated price and the original price (as reported in the SISMED), that sum least COP 800,000 million between 2019 and 2022	
Allocated Amount	0.00	0.00	11.72	11.73	11.73	11.72	0.00
Actual Value			Administrative act published in 2019	Application to 139 relevant drug markets	Circular 16/2023 published	Target achieved in 2020 (see PDI 3)	
Actual Amount			11.72	11.73	11.73	11.72	
4:Number of eligible migrants affiliated to the SGSSS (Text)		Achievement Level:					
Original/Revised Value	69,100		Administrative act from the MSPS defining the conditions in which regularly registered Venezuelan migrants (PEP holder migrants) can enroll in the	139,500	197,000	225,250	

			SGSSS, published in the Official Journal of the Republic of Colombia				
Allocated Amount	0.00	0.00	11.72	11.73	11.73	11.72	0.00
Actual Value			Decree 64/2020 published	Target achieved	Target achieved	Target achieved	
Actual Amount			11.72	11.73	11.73	11.72	

A. PROGRAM ACTION PLAN

Action	Timing	Timing Value	Achieved?	Completion Measurement
Implementation of actions to address the improvement plans presented by MSPS/ADRES to CGR; and measures included in the Punto Final Agreement.	Recurrent	Semi-Annually	Yes	Recurently the MSPS and the ADRES are following-up the CGR imporvement plans and others actions.
Comments	During the implementation of the Program, the MSPS and ADRES reported and published the improvement plan to the CGR in accordance with the deadlines established in local regulations.			
MHCP should confirm on the approval of reclassification of budgeted sources on a timely basis.	Other	After effectiveness	Yes	Closed for the first years of execution.
Comments	This activity has been completed during the first year of execution.			
CGR will provide to the Bank information on allegations of fraud and corruption, handling of said allegations, and final findings, all related to the Program and covering the MSPS, ADRES and each EPS.	Recurrent	Yearly	No	The CGR reports as part of the audit process information on allegations of fraud and corruption.MSPS reports as Dec2022, there was no evidence of materialization of fraud and corruption risks associated with the program within

				the entity's report
Comments	The CGR included, as part of the audit, the citizen complaints/requests and the follow-up (audits 2022 and 2023). The CGR will conduct the 2024 audit during the first half of 2025. The report will be submitted within the agreed deadlines.			
CGR will deliver the Program's Annual Financial Audit on time, as agreed on the MoC	Recurrent	Yearly	No	The CGR is delivering the Annual financial audit according to the agreed in the legal documents.
Comments	FY 2022 and 2023 audits were submitted to the Bank within the agreed deadlines. The CGR will conduct the audit for 2024 during the first half of 2025. The report will be submitted to the Bank within the agreed deadlines.			
HCW: 1) Monitoring plans of health facilities, developed. 2) Statistical information of waste streams, implemented on selected facilities. 3) Updating the RESPEL system annually.	Recurrent	Yearly	Yes	1) Audit reports. 2) Statistical information of waste streams in their categories, discriminating waste streams of Y1 in subcategories, implemented by the Environmental Authorities, on selected IPSs. 3) Information loaded annually into the RESPEL.
Comments	Disaggregated information was obtained for Healthcare Waste Y1-A4020 in the period 2018/22. Respel with information as of year 2022 Respel as of year 2023 will be published before February 2025.			
Treatment and final disposition of HCW: 1) Discriminate waste streams in subcategories, through a function of the RESPEL (1: pathological waste, 2: bio sanitary waste, 3: sharps waste, animal waste) 2) Communication 3&4) Analysis and Reports.	Other	1) & 2) After effectiveness/ 3) One year after effectiveness/ 4) Two years after effectiveness	Yes	1) Minutes of the agreement for accessing to the functionality in the Registry of Hazardous Waste Generators for each of the sub-categories by the SSA, signed. 2) Communication and awareness. 3&4) Analysis and Implementation Report.

Comments	Memorandum of Understanding effective May 31, 2021. The MSPS and MADES held 17 working sessions, and Resolution 591/2024 was issued. Partial and final reports conducted.			
SISPI Implement process of stakeholder participation to advance in: 1) Stage II (Preparation of the Document, and validation of the 5th component) 2) Stage III (Issue a MSPS Admin. Act for the approval of the Permanent Conciliation Table).	Other	Stage II (Six months after effectiveness) Stage III (One year after effectiveness)	Yes	1) Document prepared 2) Document approved.
Comments	The SISPI decree was prepared through meeting and Prior consultation a with Permanent Conciliation Table. It was approved in October 2024 through the Congress of Indigenous Peoples and will be submitted for the President's signature.			
For Afro-Colombian, Raizales and Palenqueras communities and the Rom people: Implement the process of stakeholder participation to advance in the pending stages to reach the guidelines for a socio-cultural adaptation of the intercultural approach.	Other	One year after effectiveness	Yes	Consultation process with the interested parties, for the construction of technical guidelines of deferential approach for black Afro-Colombian, Raizales and Palenqueras communities, dully documented.
Comments	Afrocolombian Guidelines were agreed and adopted through Resolution 1964/2024. To prepare a draft guidelines with Rom people a prior consultation was held with their representative organization in 2024, and its protocolization is pending.			
Submit the status of the improvement plan presented to the CGR on the special audit carried out to the BDUA in ADRES in year 2019, and of any other subsequent audit that could be carried out to the BDUA.	Recurrent	Semi-Annually	Yes	According to what was reported in the mission; All the findings derived from the special audit of the BDUA were closed as of December 31, 2021 and the improvement plan was assessed by the CGR as satisfactory – effective
Comments	According to what was reported in the mission, all the findings derived from the special audit of the BDUA as of December 31, 2021, were closed, and the improvement plan was assessed by the CGR			

	as satisfactory – effective			
Capacity building in the process of collecting the data for reporting financial execution and DLIs.	Recurrent	Semi-Annually	No	DLIs reports acceptable to the WBG, submitted in a timely manner.
Comments	The compliance and evidence of the result achieved for DLR 3.3 was submitted to the Bank on May 10, 2024, and it was found adequate. There are three DLRs pending disbursement, expected between June and August 2025.			

ANNEX 2. BANK LENDING AND IMPLEMENTATION SUPPORT/SUPERVISION

A. TASK TEAM MEMBERS

Name	Role
Jeremy Henri Maurice Veillard	Team Leader
Vanina Camporeale	Team Leader
Flor Maritza Martinez Camargo	Financial Management Specialist
Sandra Ximena Enciso Gaitan	Procurement Specialist
Elkin Adolfo Pinilla Canon	Procurement Specialist
Olga Carolina Rojas Orjuela	Environmental Specialist
Marcelo Roman Morandi	Environmental Specialist
Carlos Alberto Molina Prieto	Social Specialist
Ana Elena Khouri Naissir	Counsel
Rocio Mariela Malpica Valera	Counsel
Angelica Calderon	Procurement Team
Sara Daniela Garcia Rodriguez	Procurement Team
Maria Virginia Hormazabal	Team Member
Patricia Rodrigues de Melo	Team Member
Viviana A. Gonzalez	Team Member
Concepcion Aisa Otin	Team Member
Maria Cecilia Zanetta	Team Member
Gabriel Eduardo Aguirre Martens	Team Member
Ana Maria Lara Salinas	Team Member
Gisela Mariela Garcia	Team Member
Mathew David Romero Perez	Team Member
Maria Eugenia Barbieri	Team Member

B. STAFF TIME & COST

Stage of Project Cycle	Staff Time & Cost	
	No. of Staff Weeks	US$ (including travel and consultant costs)
Preparation		
FY19	18.863	192,562.15
FY20	47.483	451,042.50
FY21	4.524	27,472.87
FY23	0.000	3,393.00
Total	70.87	674,470.52
Supervision/ICR		
FY20	6.025	128,257.29
FY21	18.150	288,149.12
FY22	16.618	256,317.91
FY23	24.453	437,234.29
FY24	10.103	106,070.65
FY25	13.572	98,913.35
Total	88.92	1,314,942.61

ANNEX 3. PROGRAM EXPENDITURE SUMMARY

Source of Program Financing (US$)	Type of Co-Financing	Estimates at Appraisal	Actual Expenditures (Disbursement)		
			Actual	Percentage of Appraisal	Percentage of Actual
IBRD 9072-CO	Loan	150,000,000.00	123,438,000.00	6.22	6.33
TF TF0B2826	Concessional GCFF	37,500,000.00	30,935,000.00	1.56	1.58
Borrower Financing	**NA**	1,795,400,000.0	1,795,400,000	90.54	92.09
Total		1,983,000,000.00	1,949,773,000.00	98.32	100.00

Note: Disbursements of DLRS 1.2 and 2.4 are expected in June 2025 and for DLR 2.3 in August 2025, so fully disbursements of loan and TF proceeds are expected.

ANNEX 4. BORROWER'S COMMENTS

1. The following is a direct extract and summary of the closing report of the Improving Quality of Health Care Services and Efficiency in Colombia PforR prepared by the CCSS and submitted by the MSPS to the WB. This extract was translated to English by the WB; any mistakes in translation are the sole responsibility of the WB. The Borrower reviewed the final draft version of the ICR.

2. **Overview of program objectives and the extent to which they were achieved.**

The *general objective* of the program was to: Improve the efficiency in the expenditure of the General Social Security System in Health (SGSSS) through the use of indicators for the disbursement of a credit for results in order to improve quality patient care in a financially sustainable system.

This in turn was divided into two specific objectives: i) to improve the quality of health service delivery and ii) to improve the efficiency of health spending to guarantee the financial sustainability of the SGSSS, preserving the achievements obtained in terms of coverage, equity and financial protection. In addition, there were social, environmental and fiduciary action plans.

With respect to development indicators (ODPs), the final target was achieved in all of two (2) of the three (3) indicators. On the other hand, regarding the four disbursement indicators (DLIs), to date, the MSPS achieved compliance with the thirteen (13) results linked to disbursement (DLRs) and US$ 154.4 million were disbursed, that is, 82% of the total funds allocated, a result that corresponds to the fulfillment of ten (10) result indicators of results (DLRs).

With regard to the Intermediate Result Indicators (IRI), 11 of the 12 indicators were met, taking into account that in the restructuring process it was necessary to eliminate the indicator Ministerial *Decree on SOGC approved and issued*, in view of the fact that the MSPS is currently working on the integrated health quality system. to incorporate the guidelines of a Preventive and Predictive Health Model based on the PHC strategy, centered on the person, and focused on the continuous improvement of the quality of health care. On the other hand, the IRI not reached corresponds to the "*Deployment of pilot for pre-trial agreements to new departments".* The implementation of this activity presented difficulties due to the need to involve entities external to the Ministry, such as the Superior Council of the Judiciary and the Superintendence of Health. In this regard, various inter-institutional working groups were held, the result of which was the preparation, by the Ministry of Health and Social Protection, of a technical document that establishes standardized guidelines for the formation and implementation of "Health Management Offices" in the Departments. These guidelines are based on the successful experience of the Health Management Office of Manizales, Caldas. This process involves an operational framework that facilitates coordination, negotiation and mediation between the key parties of the sector, promoting solutions outside the judicial offices, allowing the reduction of tutela actions. Between 2020 and 2024, 71% of users who attended the Manizales Health Management Office did not file a tutela action, resulting in an impact of 10,351 fewer tutelas in the judicial system. It is expected that the proposed guidelines will allow the future implementation of Management Offices in other departments.

3. **Detailed Analysis of Program outcomes and impact**

1. **Program Development Objectives (PDOs)**

With respect to the PDOs, two (2) of the three (3) indicators were reached; (i) the *PDO 1. Increase in the percentage of women with Early Detection at the time of diagnosis* reached a value of 51.95% in December 2022, which is below the goal

agreed in the last restructuring of 55%,[71] (ii) *PDO 2. Management Index for Public Hospitals (composed of 24 indicators)* achieved a value of 75.88% in December 2023, exceeding the goal of 70% and (iii) *PDO 3. Efficiency gains achieved during the period 2020-2022 with new regulations in the pharmaceutical market* exceeded the goal of COP $800 billion with a savings of COP $946 billion.

2. Improve the quality of health service delivery

DLI 1: Updated and new regulations defining the processes and standards for certification (habilitation) and accreditation of healthcare providers that include environmental management standards.

During the implementation of the program, it contributed to the improvement of the quality in the provision of health services through the updating and issuance of new regulations that determined the processes for the qualification and quality standards of health service providers, in order to strengthen them and, in turn, Integrate environmental management standards to promote that providers have the capabilities to adapt to environmental changes, respond to natural emergencies, as well as ensure environmental and energy savings.

To achieve the above, the licensing standards of the Health Service Provider Institutions (IPS) were updated[72], which given the exceptional circumstances in which the providers found themselves during the pandemic, it was necessary to adjust the deadlines for verification and certification, as well as the plan of authorization visits by the health secretariats and their respective registration in the application called Special Registry of Health Service Providers (REPS). This Ministry, thanks to joint work with interest groups and experts, included the outpatient chemotherapy modality in the respective regulations, in order to improve the accessibility, timeliness, quality and satisfaction of care for cancer patients.

Likewise, the specific quality processes and standards for the accreditation of hospitals with an emphasis on low-complexity services were determined through Resolution 1328 of 2021, which was incorporated into the Accreditation Manual in Ambulatory and Hospital Health of Colombia. One of the regulated standards is that of a safe and environmentally responsible environment, as well as the security of the management of inputs and supplies. This was complemented with the issuance of Resolution 591 of 2024, which adopts the Manual for the Comprehensive Management of Waste Generated in Health Care and Other Activities, determined jointly by the MSPS and the Ministry of Environment and Sustainable Development. After the issuance of the standard, a technical assistance plan was developed.

In addition, the publication of the executive summary of the "Estimation of the carbon footprint of the health sector in Colombia" is [73] highlighted, in which the report of a sample of 265 IPS reports, on the calculation of the carbon footprint, is analyzed.

On the other hand, within the framework of the National Development Plan 2022 – 2026[74], a prioritization of health services based on Primary Health Care (PHC) was determined, with the implementation of a preventive and predictive model, strengthening the quality of the primary level of care. Taking into account the above, the milestone related to the accreditation of Health Promoting Entities (EPS) was modified and, consequently, the MSPS issued the administrative act that defined the quality attributes for primary health care service providers, which promote environmental sustainability (Resolution 2696 of December 27, 2024). One of the attributes is sustainability, which has a focus on the conservation of natural resources, reduction of carbon footprint and recycling practices and final disposal of waste. In this administrative

[71] The adjustment of the target is originally 69% to 55%, according to the latest restructuring signed on December 20, 2024.
[72] Making modifications to Resolution 3100 of 2019, through resolutions 2215 of 2020, 1317 of 2021, 1138 of 2022, 1410 of 2022, 1719 of 2022, 544 of 2023 and 648 of 2023.
[73] https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/SA/proyecto-estimacion-huella-carbono-sector-salud-colombia.pdf
[74] Law 2294 of 2023

act, it was also determined that the MSPS, together with the territorial entities, will provide assistance and technical support to providers who require it.

In addition, it was possible to increase the number of low-complexity public hospitals technically assisted in the accreditation process to 132, with 2 hospitals as a baseline at the beginning of the program and exceeding the goal of 60 hospitals assisted that complied with the corresponding indicator.

Likewise, the number of quarterly reports of public disclosure of key performance indicators for public hospitals was increased from 2 to 18[75], exceeding the goal of 14 reports. These reports aim to analyze the results of the Composite Hospital Management Indicator, which evaluates the performance of State Social Enterprises (ESCOs) at the national level, based on three critical components: i) quality of health care, ii) financial performance, and iii) fulfillment of the public health functions assigned to ESCOs. This indicator was constructed from the weighting of 24 individual indicators reported by 931 ESCOs in 794 municipalities of the country.[76]

On the other hand, it sought to strengthen the training and development of human talent in health, through the issuance of Decree 376 of 2022, which established the guidelines for the continuous training system for human talent in health, the training and permanent updating of workers in the sector in alignment with the needs of the health system and thus impact the quality of health services. In 2024, we collaborated with the Pan American Health Organization (PAHO) and the National Learning Service (SENA) to strengthen the training offer, guaranteeing free access. With respect to this point, it is considered necessary to highlight that the articulation of the education, health and labor sectors is key and that the training offered is aligned with the needs of the population, the labor market and the health and care models.

Similarly, and in order to provide greater access, opportunity and resolution in the provision of health services, Resolution 2654 of 2019 was issued, which defined the parameters of telemedicine in Colombia, which made it possible to improve the quality of the same provision, especially in remote areas of the country.

On the other hand, in 2020, the 2015 Law was determined, through which the Interoperable Electronic Medical Record was regulated, an initiative that contributes to a better continuity of care through the exchange of information between institutions, facilitating access to timely information for health professionals for clinical decision-making that will have an impact on an improvement in the quality of care. Subsequently, in 2021, the set of relevant clinical data for the interoperability of the medical record in the country was regulated, through resolution 866, in conjunction with the Ministry of Information and Communication Technologies. In 2022, the technical implementation guides and the regulatory project that defined the operating model were prepared. Likewise, progress was made in the development of technological solutions and the prioritization of territories for implementation was carried out, in three phases. This is how it began with the accompaniment of the prioritized territories and permanent technical support, from the platform to the providers of these regions.

All the aforementioned actions carried out in the course of the program, including the updating of standards for the authorization and accreditation of the IPS, with emphasis on environmental care and PHC, as well as the regulation and implementation of telemedicine, the Interoperable Electronic Medical Record and the strengthening of human talent in health, they are intended and focused on improving the quality of health care.

DLI 2: Incentives introduced to the payment system to achieve better quality in health care and greater efficiency in the diagnosis and treatment of cancer.

[75] Corresponds to March, 2024

[76] https://sig.sispro.gov.co/sistemaalertashospitales/

In order to achieve better quality and efficiency in the diagnosis, treatment and care of cancer in Colombia, the MSPS carried out the following measures.

In 2019, the calculation and distribution methodology that defined the ex-post values in the Capitation Payment Unit (UPC) was established and implemented to encourage EPS with efficiency in the risk management of 11 prioritized cancers, through Resolution 3339. The first cancer prioritized in this administrative act is breast cancer. To this end, an analysis of the bases of the reports of cancer patients was carried out[77].

Likewise, the instructions for the strengthening of actions for cancer control - Cancer Shock Plan were determined, through Circular 10 of 2024. This was an inter-institutional work between the MSPS, the National Cancer Institute and the National Superintendence of Health (SNS). The Circular contains immediate, strategic and operational actions for all entities responsible for interventions related to the prevention, early detection and comprehensive care of cancer, including breast cancer. The plan is composed of five elements: (i) organization of the network, (ii) strengthening of human talent, (iii) quality assurance, (iv) information, education and communication, and (v) monitoring and follow-up. In addition, the corresponding communication strategy was carried out on the plan "Preventing takes time", technical assistance to all territorial entities and EPS to provide guidance in the deployment of the plan and courses, for human talent, in early detection of cancer. Subsequently, the viewer for monitoring the action plans was designed.[78]

In this regard, it should be noted that the percentage of women with early detection at the time of diagnosis was increased. Taking into account the restructuring of the program, with a baseline of 49.86%, it was increased to 51.95%,[79] exceeding the target of 51.5%. Similarly, the percentage of women between 50 and 69 years of age with breast cancer screening, according to the defined protocols, exceeds the goal of 30%, increasing from 21.2% in 2019 to 37.92% in 2023[80].

On the other hand, the "Horizon Matrix Technologies in Health 2021-2022" was published, validated with scientific societies and actors of the health system, in which a methodology was defined for the identification, prioritization and evaluation of technologies not financed with UPC resources, to be included in the Benefits Plan. A total of 668 drugs and 75 procedures not financed with UPC resources were identified, for a total of 743 technologies prioritized for financing with UPC resources. To date, 100% (75) of the procedures and 91.1% (608) of the medicines have been included in the Benefits Plan, which represents an improvement in the coverage of services and technologies, contributing to the quality of the health service.

Additionally, in May 2022, the document that accounts for the risk adjustment methodology for health conditions was published. However, the implementation was not approved by the advisory commission, given the fiscal implications in contexts of budgetary adjustments.

Since the management of PQRSD, the MSPS strengthened the process of processing the requirements filed by citizens, in accordance with the times provided by regulations for each type of application, Likewise, the PQRSD Management Strengthening Route was implemented, which considers components such as: (i) strengthening in the distribution of PQRSD, (ii) socializations management monitoring reports through indicators by type and dependency, (iii) general and focused training and technical assistance, (iv) office developments to support the management of PQRSD and (vi) updating of processes and procedures, based on the potentiation of qualifications and competencies of the technical team of citizen

[77] Resolution 247 of 2014 and 4505 of 2012
[78] https://lookerstudio.google.com/u/0/reporting/3002c6d4-350f-4ddf-85d9-fd6d3b85b628/page/p_0zj5gghbfd
[79] Distribution mechanisms – Cancer 2024. https://www.minsalud.gov.co/salud/POS/Paginas/unidad-de-pago-por-capitacion-upc.aspx.
[80] RIAS Monitor Health Promotion and Maintenance https://web.sispro.gov.co/WebPublico/Consultas/MonitorRIAS.aspx

service through the different service channels that positively impact the change of organizational culture in terms of compliance in terms of quality and timeliness in responses.

3. Improve the efficiency of health spending to ensure the financial sustainability of the (SGSSS)

DLI 3: Increased efficiency in pharmaceutical spending as a result of regulatory policies in the pharmaceutical market.

In relation to increasing efficiency in pharmaceutical spending, in order to promote the financial sustainability of the system, a series of regulatory policies focused on the pharmaceutical market were issued and implemented during the course of the program.

In April 2020, 111 new relevant markets were added to the direct control regime, through Circulars 10 and 11, and additionally Circular 12 of 2021. With these additions, the indicator of applying the current price regulation methodology according to Circular 3 of 2013 was met, emphasizing at least 50 new relevant markets. This generated an average reduction of 40% in the price of about 1,000 commercial presentations. Subsequently, in 2022, as of Circular 13, another 128 new relevant markets were added to the direct control regime.

Additionally, in 2023, the methodology for the control and regulation of the introduction of high-cost medicines into the market was defined through Circular 16, which established the methodology for setting the price of new medicines, defined by the National Commission on Prices of Medicines and Medical Devices. With the issuance of this regulation, the provisions of Article 72 of Law 1753 of 2015 are complied with, so that new medicines can enter the market with a regulated price and according to their therapeutic value. In the search for greater efficiency in pharmaceutical spending, it is suggested to encourage the implementation of centralized negotiation of high-cost medicines. It is worth mentioning that the MSPS established the criteria for the centralized purchase, distribution and supply of antiretroviral drugs for the Human Immunodeficiency Virus (HIV), through Resolution 2164 of 2024. This measure is expected to treat more people living with HIV, with an emphasis on Venezuelan migrants, since the value of annual treatment per patient decreases, allowing efficiencies in spending in the health system.

Subsequently, the methodology for regulating drug prices was defined, through Circular 18 of 2024, setting a Maximum Sale Price - PMV of medicines, applicable to all entities involved in the purchase and sale of medicines, both in the institutional and commercial spheres. This methodology focused on generating a fair, equitable, transparent pricing system aligned with international standards and market dynamics. It should be noted that this is an update to the methodology determined in 2013, which was valid for 10 years. This update is intended to achieve greater efficiency in health sector spending and facilitate access to medicines. In order to further expand spending efficiency, it is suggested to regulate and implement a similar initiative for price regulation to relevant medical device markets.

As a complement, in 2021 and 2022, four (4) bulletins were published that analyzed the pharmaceutical market for the incorporation of medicines and medical devices into the probation regime (probation and direct control). The bulletins analyzed the market for: i) coronary medical devices, ii) contraceptives, iii) out-of-pocket expenditure, and iv) price thermometer. Through the publication of these bulletins, the use and analysis of available information on the prices of medicines and medical devices was promoted, as well as facilitating its access and understanding for citizens and interested actors.

The sum of all the regulatory measures implemented leads to efficiency gains, due to the difference between the regulated price and the price before regulation, reaching a savings of COP $946,000 million in 2020, exceeding the established goal

by 18% and being met two years before the originally established period. These savings contributed to the financial sustainability of the health system.

DLI 4: Eligible migrants affiliated to the General Social Security Health System (SGSSS).

Taking into account the migratory context of the neighboring country of Venezuela and the impact on the financial sustainability of the Colombian SGSSS, given the guarantee of access to health for this population, in compliance with its definition as a universal right, the Colombian state facilitated the regulation and mechanisms of affiliation to the health system for this vulnerable population.

First, the conditions and mechanisms for affiliation of Venezuelan migrants with Special Residence Permits – PEP to the SGSSS, stipulated in Decree 64 of January 2020, were defined. This population is then identified as beneficiaries of the Subsidized Health Regime and the prerequisite of the SISBEN survey for affiliation is eliminated.

After the issuance of Decree 64 of 2020, and on a permanent basis, the MSPS has provided technical assistance to all territorial entities and EPS related to the health affiliation of the Venezuelan migrant population. In addition, a virtual course supported by the World Bank on this topic was implemented. Similarly, mass delivery days of Temporary Protection Permits – PPT to Venezuelan migrants were carried out led by Migración Colombia and accompanied by the MSPS, to simultaneously carry out the affiliation to the SGSS, in different cities of the country. This has ensured a steady increase in affiliations, contributing to the socio-economic integration of this vulnerable population.

From that moment, January 2020 and until November 2024, 1,560,374[81] Venezuelan migrants were affiliated to the SGSSS, representing 55.57% of the 2,808,165[82] (Nov, 2024) who are in Colombia and 64.39% of those with a regular migratory status, 2,423,222[83] (Nov, 2024). This number of affiliated Venezuelan migrants exceeds the goal established in the program (225,250).

On the other hand, in relation to the impact of the increase in migrant affiliation coverage, the Directorate for the Regulation of the Operation of Health Insurance, Occupational Risks and Pensions. of the MSPS, identified the need to go beyond the measurement of coverage measured by affiliation or service provision, and to be able to present the country with a measurement of barriers and effective access to health services.

4. Social, environmental, and fiduciary action plans

4.A. Social Action Plan:

As a result of the process carried out by the MSPS between 2022 and 2024, the guidelines for a sociocultural adaptation of the health service were generated, built with the participation and agreement through prior, free and informed consultation with each of the Colombian ethnic groups. This contributed to strengthening the adoption and integration of intercultural approaches in the health system.

- With indigenous peoples, more than 9 working groups were held with the indigenous health subcommittee of the Permanent Roundtable for Consultation. In 2024, the Decree of the Indigenous Intercultural Health System (SISPI) was prepared and approved by the Congress of Indigenous Peoples.

[81] https://www.sispro.gov.co/observatorios/onmigracionysalud/Paginas/Migrantes-afiliados-a-Salud.aspx
[82] https://public.tableau.com/app/profile/migraci.n.colombia/viz/MigrantesvenezolanosenColombia-Junio2024/MigrantesvenezolanasosenColombia

- With the Black, Afro-Colombian, Raizal and Palenquera (NARP) communities, 4 sessions were held between 2022 and 2024, and 34 meetings with their representative organizations. The guidelines for the implementation of the differential ethnic approach in health for NARP communities were agreed upon in 2024 and adopted in Resolution 1964 of 2024.
- With the National Space for Roma Dialogue, 11 workshops and several working groups were held with the RROM people. The document "Health Policy Guidelines with a Differential Approach for the RROM People within the framework of the SGSSS" is in draft form at the end of 2024 and a final version is expected when the prior consultation agreements are protocolized and integrated into an administrative act of the MSPS.

On the other hand, the articulating mechanism for the Comprehensive Approach to Gender-Based Violence against women, children and adolescents was created through Decree 1710 of 2020. It is worth mentioning that work is being done to finish implementing the Articulating Mechanism for intersectoral coordination to respond to gender-based violence in the place, in all departments (100%), districts (82%) and municipalities (70%) of the country. Technical assistance was and will continue to be carried out, as well as the periodic evaluation of results. For this topic, it was key to understand the differences in the context and how they manifest themselves in violence.

4.B. Environmental Action Plan:

Since 2021, the monitoring of the behavior of the Inspection, Surveillance and Control (IVC) began to be implemented, thus initiating the "internal management report of health care waste corresponding to the previous year" by the Territorial Health Directorates (DTS) in compliance with article 2.8.10.9. of Decree 780 of 2016 and in accordance with the provisions of Resolution 1229 of 2013. In this regard, it should be noted that the program promoted the monitoring of the implementation of the activities provided for in the regulations, in a systematic and consolidated manner.

Departments report waste generated in the previous year to national authorities. Subsequently, the national environmental authority (Institute of Hydrology, Meteorology and Environmental Studies - IDEAM) reviews and consolidates the information in a RESPEL report. Through the 2021 Act, it was agreed with IDEAM, that the Subdirectorate of Environmental Health (SSA) of the MSPS would be able to access the disaggregated information of hazardous waste and have this information prior to the publication of the Hazardous Waste report (RESPEL).

The information collected was used as an input for the update of the GIRASA Manual (Integrated Management of Health Waste), concluding in Resolution 591 of 2024, which adopted the Manual for the Comprehensive Management of Waste Generated in Health Care and Other Activities, determined jointly by the MSPS and the Ministry of Environment and Sustainable Development. In this resolution, it was determined that waste must be managed comprehensively in order to prevent and reduce risks to public health and impacts on the environment. This Manual updated the provisions of Resolution 1164 of 2002, with the respective 18 months of transition, by which the manual of procedures for the comprehensive management of hospital and similar waste had been adopted, taking into account new scientific knowledge on the risks, treatments and technologies of the handling of waste with biological or infectious risk. Subsequently, technical assistance sessions were provided to support its implementation.

On the other hand, during the years 2021 to 2023, the census report of waste generators of health care establishments was prepared annually. In addition, Resolution 367 of 2023 was issued, which established the process for strengthening environmental health management at the territorial level.

These processes contributed to strengthening the Unified Environmental Health Information System (SUISA), a knowledge management system, which collects and captures the information produced by the sectors for the analysis of social and

environmental determinants and their effects on the health of the population, which supports intersectoral decision-making.

4.C. Fiduciary Action Plan:

Periodically, the MSPS and ADRES followed up on the improvement plans submitted to the Office of the Comptroller General of the Republic (CGR). From the audit carried out on the BDUA in 2019, the CGR declared the improvement plan as effective.

i) Fraud and Corruption: The MSPS and ADRES confirmed that, according to the information available, there was no evidence of fraud and corruption risks materializing in the Program.
ii) Financial reports and audits of the Program: As of June 30, 2024, the MSPS submitted the semi-annual financial reports, as well as the annual audit reports within the deadlines and contents agreed with the World Bank.

5. Lessons learned that could be applied to future projects.

Taking into account that the commitments of the Program are established within the framework of government policies and plans, as well as in the mission of the MSPS, one of the beneficial effects of the program is the stimulus and commitment it generates on the MSPS to promote the development of regulations identified as essential and promote the implementation of measures that were already regulated. with the purpose of meeting the objectives of efficiency of expenditure and quality in the provision of health services.

In this regard, it is a great incentive to have international cooperation that contributes to the fulfillment of the agreed indicators, through expert advisors who provide technical support based on lessons learned or identified needs, through international experience and expertise. This materialized in more than twelve technical assistances provided by the World Bank, which were valuable in strengthening the capacities of the MSPS team and the results of the program, such as: international best practices for the early detection of breast cancer.

With respect to the last mentioned, as a lesson learned in the execution of this program, it is suggested to identify, from the different areas that will carry out the development of the program, the possible technical assistance necessary from the beginning, in order to take advantage of the opportunity for learning and joint construction in the best way. In this case, they were requested from the banks throughout the project. This suggestion contributes to improving planning for the parties, as well as to maximizing human resources and training possibilities and spaces with allied countries that have enriching experiences that favor cross-learning.

It is also important to highlight the possibility of taking advantage of the support of the Bank for the development of training courses that improve the implementation of policies and regulations in the territory, as was carried out on the issue of migrant affiliation.

With respect to the social action plan, the dialogue tables with the different ethnic bodies, it is worth mentioning that these allowed the MSPS to identify priority care needs for these communities, recognizing that they encounter different barriers to access the health system on which they can continue to work, within the framework of a stronger relationship with ethnic groups.

On the other hand, the articulation of the MSPS with the Ministry of Environment and Sustainable Development (MADS) and IDEAM was key to fully implement the environmental action plan. From the above, it should be noted that a working

group was established with institutions of the health sector and environmental and sanitary authorities, with which 17 working sessions were held for the collection, consolidation, analysis and processing of information, and the guidance document for the classification and reporting of hazardous waste generated in health care and other similar activities was prepared.

6. Challenges or obstacles encountered during the implementation of the project and how they were addressed.

One of the challenges encountered during the implementation of the project is that the duration of the project was in the period of implementation of two national development plans. Taking into account the definition of the health model and the prioritization of the strengthening of certain institutions or entities, in accordance with the national development plan, the definition of the indicators and their corresponding goals may be impacted.

This is reflected, for example, in the need to restructure and modify the indicator of the "Administrative act defining processes and criteria for the accreditation of EPS that include quality and environmental management standards" to that of "Administrative act that defines quality attributes for providers of Primary Health Care services, that promote environmental sustainability" given the orientation of strengthening the primary level of care, with a territorial approach.

Similarly, it should be taken into account that the MSPS is currently working on the integrated health quality system, which is consistent with a Preventive and Predictive Health Model based on the PHC strategy, centered on the person and focused on the continuous improvement of the quality of health care. As the integrated health quality system is in the process of construction, in coherence with the formulation of public policies on quality in health and humanization in health that is also underway, and in accordance with the approved schedule, it will conclude in the second half of 2025; the elimination of the intermediate indicator called the Ministerial Decree on the Mandatory System of Quality Assurance in Health (SOGCS) was required.

On the other hand, the contingency caused by the Covid-19 pandemic, which was experienced during the execution of the project, also resulted in the prioritization of certain services, affecting the reduction of those of promotion and prevention, such as screening exams. That is why, with respect to the indicators of early detection of cancer, adjustments were made to both the baseline and the expected goal. The initial baseline (55.7%) is adjusted to 49.86% and the original goal (66.3%) to the adjusted (51.5%), taking into account that during the pandemic and confinement period, promotion and prevention exams were the ones that showed the greatest decrease, impacting the timely diagnosis of cancer in early stages.

With respect to the operational challenges identified, it is relevant to mention the importance of the continuity of the professionals who are in charge of carrying out the processes necessary for the fulfillment of objectives and goals, including the construction of regulations. When the above is not possible, it is necessary to strive to guarantee the continuity of knowledge and the methodologies applied. Similarly, there is the challenge of high staff turnover in the territorial health secretariats, which reinforces the importance and value of perseverance in technical assistance to, among other things, enroll the migrant population in the SGSSS and consolidate capacities.

However, specifically, with regard to the implementation of the social action plan, it was evident that the conditions for participation with ethnic groups must be agreed upon to guarantee respect for their times, forms of government and mandates, which structurally corresponds to a continuous challenge.

7. Recommendations to sustain and expand the project's achievements.

Among the recommendations to maintain the project's achievements over time, the following can be considered:

The creation of audiovisual resources (videos, tutorials, webinars, etc.) for the socialization of the most representative experiences of the program is crucial to document and disseminate the learning and results of the project in an accessible and attractive way, taking into account the inclusion of diverse communities. The foregoing, prioritizing activities that involve citizen participation. To this end, planning can be carried out from the beginning of the program focused on promoting activities that have a potential scope, so that cooperation resources can be allocated in this regard.

Along the same lines, the possibility of creating training modules in audiovisual or interactive format is raised, as it can be a fundamental tool to ensure that the knowledge acquired during the project continues to be transmitted.

Finally, a fundamental recommendation identified to sustain the achievements of the project is to continue with the articulation of the entities involved and maintain continuous and constructive communication, for example with the National Commission on Prices of Medicines and Medical Devices, the Institute of Health Technology Assessment (IETS), the National Cancer Institute, the National Superintendence of Health, the National Institute for Drug and Food Surveillance (INVIMA), the Institute of Hydrology, Meteorology and Environmental Studies (IDEAM), the Ministry of Environment and Sustainable Development, the Ministry of Information and Communications Technologies, the National Learning Service (SENA), Migration, ADRES, among other entities. In other words, it is recommended to continue strengthening inter-institutional coordination to sustain and expand the project's achievements.

ANNEX 5. ADDITIONAL EVIDENCE SUPPORTING PDO ACHIEVEMENT

Additional evidence supporting PDO 1 achievement under DLI 2

1. While it is not possible to establish a direct attribution, the actions implemented by the MSPS with the Program's support (i.e., the implementation of ex-post-performance-based financial incentives and the two cancer action plans) likely contributed to the significant improvements in both access and quality in the screening, diagnosis and reporting of breast cancer from 2018 (original baseline) to 2022 (latest data available).[84] There were also substantial improvements in the opportunity of diagnosis and treatment. These trends are summarized in Box 5.1: [85]

Box 5.1 Improvements in Access and Quality of Breast Cancer Care in Colombia, 2018-2022

Total number of breast cancer cases monitored and reported in Colombia – 2015-2018 versus 2019-2022

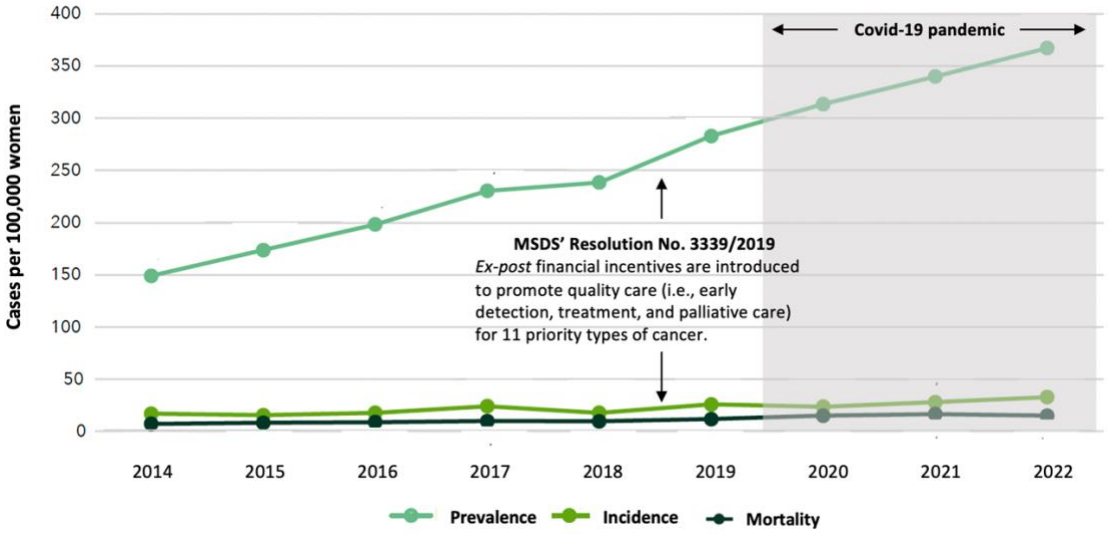
- Figure 5.1 clearly shows the marked increase in the rate of change (slope) in the number of cases of breast cancer cases (both all and new cases) in 2019, likely to be at least partly linked to the reporting requirements for the new *ex-post* financial incentives going into effect that year.

[84] In the case of breast cancer, screening is of particularly critical importance, as that is how it is typically detected. The five major cancer types vary in how they are typically detected: through screening (female breast and prostate cancer), due to symptoms (lung and bronchus and pancreatic cancer), or incidentally during other medical procedures (thyroid cancer).

[85] Elaborated by the author based on cancer statistics: (i) for Colombia, CAC (2019-2024), *Situación del cáncer en la población adulta atendida en el SGSSS de Colombia – 2018-2023*, Bogotá. [https://cuentadealtocosto.org/cancer/]; and (ii) for global cancer statistics, Bray, F., Ferlay, J., Soerjomataram, I., Siegel, R.L., Torre, L.A. and Jemal, A. (2018), Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA: A Cancer Journal for Clinicians, 68: 394-424. [https://doi.org/10.3322/caac.21492]
Bray F, Laversanne M, Sung H, et al. Global cancer statistics 2022: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2024; 74(3): 229-263. [doi:10.3322/caac.21834]

- The number of total cases of breast cancer being monitored and reported annually between 2019 and 2022 increased significantly compared to the previous four-year period. On average, there were 326 breast cancer cases per 100,000 women reported annually between 2019 and 2022 compared to 210 between 2015 and 2018 (i.e., 55 percent higher).

Figure 5.1 Trend in Frequency Measures of Breast Cancer in Colombia, 2014 – 2022



Source: CAC (2024), *Situación del cáncer en la población adulta atendida en el SGSSS de Colombia – 2023,* Bogotá.

New breast cancer cases diagnosed and reported in Colombia 2015-2018 versus 2019-2022

- The number of new cases of breast cancer being diagnosed and reported annually increased significantly between 2019 and 2022 compared to the previous four-year period. On average, there were 28 new cases per 100,000 women reported annually between 2019 and 2022 compared to 19 between 2015 and 2018 (i.e., 47 percent higher).

New breast cancer cases in Colombia and worldwide, 2018-2020

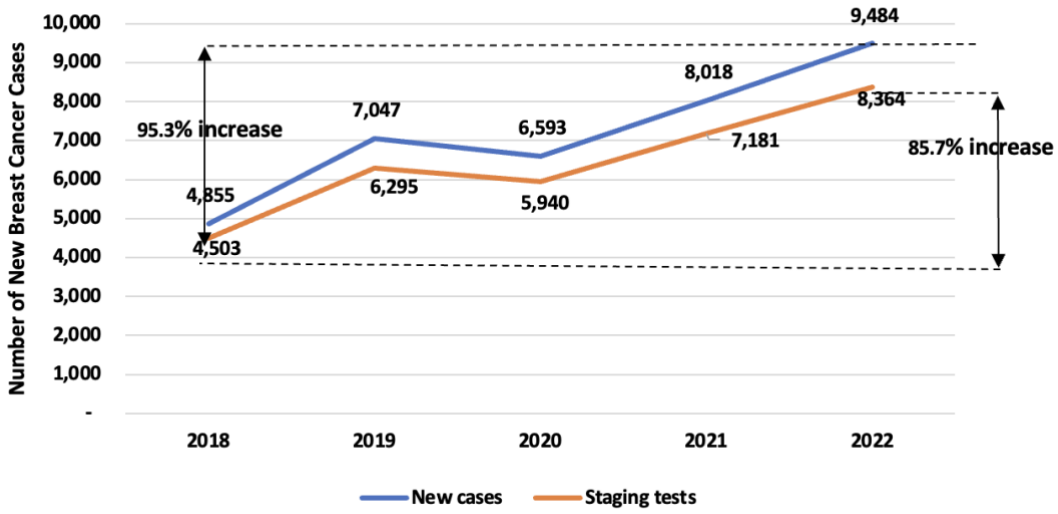
- The comparison in the increase in the incidence rate for breast cancer (new cases) between 2018 and 2022 shows a disproportionate increase in Colombia vis-à-vis the world. The significant difference suggests that there are factors at work beyond the actual increase in the number of new cases in Colombia, such as improvements in reporting and diagnosis, likely impacted by the newly implemented ex-post financial incentives.
- Between 2018 and 2022, the number of new breast cancer cases (in situ and invasive) increased by 95.3 percent (from 4,855 to 9,484) in Colombia compared to 10.5 percent worldwide (from 2.09 million to 2.31 million).
- Similarly, the crude incidence (i.e., new cases per 100,000 women) for breast cancer cases ((in situ and invasive) increased by 84.8 percent in Colombia (from 19.6 to 36.2) compared to only 6.4 percent worldwide (from 54.7 to 58.1) during the same period.

Improvements in the quality of breast cancer diagnostic services

- The number of newly diagnosed breast cancer cases that underwent tumor staging testing increased by 85.7 percent between 2018 and 2022 (i.e., from 4,503 to 8,364).
- As shown in Figure 5.2, this increase was slightly below the even more rapid increase in the number of new cases being diagnosed (i.e., 95.03 percent increase during the same period). As a result, the proportion of new cancer cases that underwent tumor staging testing decrease from 92.75 percent in 2018 to 88.19 percent in 2022 (equivalent to a 4.6 p.p. decrease).

- In the case of other types of diagnostic services, the improvements kept up with the rapid rate of increase in the number of new breast cancer cases, also showing improvements as a percentage of new cases. Specifically:
  - The proportion of patients with histopathological diagnosis before surgery increased from 91.1 percent in 2018 to 94.3 percent in 2022 (equivalent to a 3.2 p.p. increase).
  - The proportion of patients with hormone receptor (estrogen/progesterone) results increased from 83.3 percent in 2018 to 88.5 percent in 2022 (equivalent to a 5.2 p.p. increase).
  - The proportion of patients with HER2 testing increased from 87.1 percent in 2018 to 92.4 percent in 2022 (equivalent to a 5.3 p.p. increase).

Figure 5.2 Number of New Breast Cancer Cases and Tumor Staging Tests in Colombia, 2018-2022



Source: Own elaboration based on data from Cuenta de Alto Costo (CAC), *Situación del cáncer en la población adulta atendida en el SGSSS de Colombia – 2019-2023,* Bogotá.

Improvements in the opportunity of breast cancer treatment

- The average number of days elapsing between the onset of breast cancer symptoms and the first treatment decreased by 16.8 percent between 2018 and 2022 (i.e., from 116.21 to 96.74 days).
- The average number of days elapsing between the treating physician and the first treatment decreased by 31.6 percent between 2018 and 2022 (i.e., from 39.38 to 26.92 days).

Improvements in the early diagnosis of breast cancer (i.e., health outcome)

- The number of newly breast cancer cases that were detected early (in situ; Stages I and II) increased by 88.6 percent between 2018 and 2022 (i.e., from 3,082 to 5,812).[86]
- Early diagnosis plays a critical role in reducing mortality. According to the American Cancer Society, the 5-year relative survival rate is close to 100 percent for Stage 0 or I and about 93 percent for Stage II. By contrast, Stage IV (metastatic) breast cancer has a 5-year survival rate of only about 30 percent. Early detection also has a better prognosis, as early-stage tumors are often less aggressive and respond more effectively to treatment, such as surgery, radiation, and hormonal therapy. Early-stage cancers are also less likely to recur after treatment, which further improves long-term survival. They also offer options for less invasive treatments (e.g., lumpectomy instead of mastectomy).

[86] Based on CAC Situación del cáncer en la población adulta atendida en el SGSSS de Colombia – 2019-2023, Bogotá.

Improvements in cancer care for all types of cancer ▪ While this operation focused specifically on breast cancer, it is important to note that the impact of the GoC's strategic actions to control cancer have positively impacted all cancers. The significant increase in the number of new cases of cancer (all types) diagnosed and reported in Colombia vis-a-vis the increase globally serves as an illustration. While in Colombia, the number of new cancer cases (all types; in situ and invasive) doubled between 2018 and 2022 (from 29,151 to 58,813), it increased by only 10.5 percent worldwide (from 18.1 million to 20 million). The significant increase in new diagnoses is particularly noteworthy in the context of the COVID-19 pandemic.
Improvements in reporting ▪ While it is not possible to distinguish between the relative impact of improvements in diagnosis and reporting, the importance of the latter should not be underestimated. The implementation of *ex-post* incentives has contributed to better and more reporting on the part of health care providers, resulting in a significant expansion of the nominalized clinical registry of cancer patients administered by the High-Cost Account (*Cuenta de Alto Costo* - CAC). Given its national coverage, the use of a clearly defined methodology and the quality of the externally audited data (at the clinical history level), this registry provides highly valuable information not just for the administration of the *ex-post* adjustment mechanism but for public health policy decision making.

Additional evidence regarding PDOI 2 Performance Index (PI) for public hospitals (Ai Hospitals)

2. **The continuous implementation of the PI for public hospitals has enhanced accountability and transparency in relation to the performance of public hospitals.** Introduced in 2018, the PI is a compound indicator that includes 24 management indicators for public hospitals: (i) seven sub-indicators focusing on public health; (ii) eight sub-indicators focusing on quality of care; (iii) five sub-indicators focusing on financial performance (i.e., operational balance); and (iv) four sub-indicators focusing on indebtedness in relation to human resources. Public health indicators are aggregated at the territorial-entity level, while the remaining ones reflect the average of the data provided by 931 public hospitals in 794 municipalities across the country.[87] It is reported on a quarterly basis on the MSPS's external website,[88] publicly disseminating the performance of individual hospitals both at the aggregated and sub-indicator levels.

While it is undoubtedly an important tool for enhancing the efficiency of the health system, its inclusion as an outcome indicator under the Program's RF (i.e., PDOI 2) has limited justification in terms of its validity. Specifically, the compound indicator does not adequately capture PDO achievement for several; reasons, including: (i) the large number of sub-indicators included under the compounded PI, many of which had only a tenuous or no relationship with the actions supported under this PforR; (ii) the fact that hospital performance as reflected in the PI is affected by a myriad of other external factors (such as, for example, the adequacy of the UPC value); and (iii) several methodological weaknesses, including high intra- and inter-annual variability, as it is affected by seasonality and the relative strength of some key morbidities such as dengue, as well as administrative cycles. Some of these aspects are explored in further detail in Box 5.2.

Box 5.2 A deeper look into PDOI 2 PI for Public Hospitals

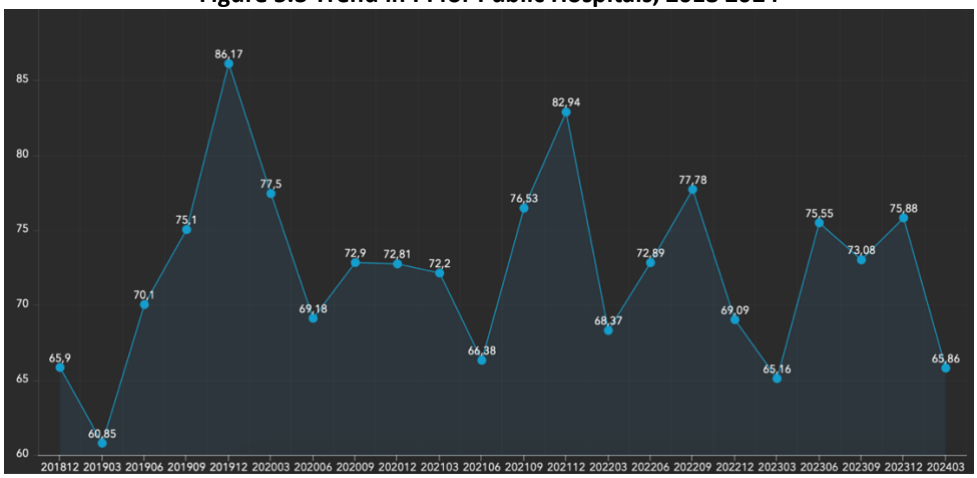
The PI has high intra- and inter-annual variability ▪ As shown on Figure 5.3, the PI for public hospitals has high *intra-annual variability* due to administrative cycles and the seasonality of some key morbidities, such as dengue (inter-annual variability). As an illustration, the PI ranged between

[87] For methodological details in terms of relative weights and aggregation rules, see: https://sig.sispro.gov.co/sistemaalertashospitales/ABC_Programa_Aihospital_V1_Abril_2019.pdf
[88] [https://sig.sispro.gov.co/sistemaalertashospitales/]

60.85 and 86.17 between March and December 2019. Thus, multi-year comparisons are deemed more appropriate when considering the same time period, preferably at the end of the fiscal year (December) when accounts are reconciled.

- It also has *inter-annual variability* due to the unpredictable morbidities (e.g., COVID-19) and the relative strength of recurrent ones (e.g., dengue).

Figure 5.3 Trend in PI for Public Hospitals, 2018 2024

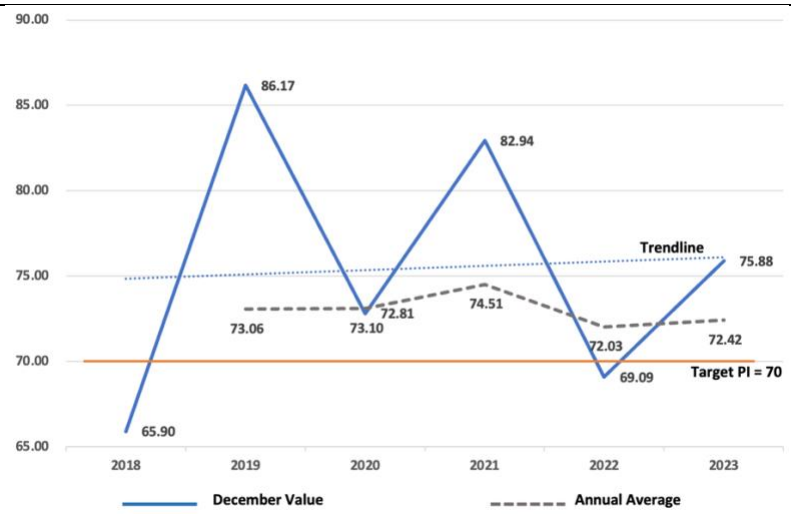


Source: MSPS [https://sig.sispro.gov.co/sistemaalertashospitales/; Accessed on March 22, 2024).

PI inter-annual comparisons

- Given the high intra-year variability, multi-year comparisons are deemed more appropriate when based on: (i) the same time period, preferably at the end of the fiscal year (December) when accounts are reconciled; or (ii) the annual average.
- When comparing year-end values (i.e., December), the overall PI increased from 65.9 to 75.88 between 2018 and 2023 (i.e., equivalent to a 9.98 p.p. increase), exceeding the target of 70. As shown on Figure 5.3, results indicate an initial increase in overall performance in 2019, followed by a series of drops (2020 and 2022) and rebounds (2021 and 2023) with an overall slightly positive trend.
- When considering the annual average, the PI decreased from 73.06 to 72.42 between 2019 and 2023. However, while experiencing some drops and rebounds, the annual average was consistently above the target of 70.

Figure 5.3 Trend in PI for Public Hospitals



Source: Prepared by the author, based on data from MSPS [https://sig.sispro.gov.co/sistemaalertashospitales/; Accessed on March 22, 2024).

Performance at the sub-indicator level

- *Public Health:* As shown on Table 5.1, the overall performance in this area has been positive, with improvements in five out of the seven sub-indicators, with one of the remaining two showing no change and the other one lacking data. Improvements were particularly significant in terms of infant mortality (from 39.9 to 7.1 deaths of infants under one year of age per 1,000 live births between 2019 and 2024).
- *Quality of care:* Results in this area are mixed, with four out of the eight sub-indicators showing improvements and the remaining four showing a reversal.
- *Operational balance:* Results were also mixed in this area, with four sub-indicators showing improvements and the remaining two showing a reversal.
- *Level of indebtedness with respect to human resources:* Results in this area are consistently poor, with the debt to contractors skyrocketing between 2019 and 2024 and greater delays in payments to employees and third-party personnel.

Table 5.1 Change in PI Sub-Indicators from 2019 to Latest Available Data (2023 or 2024)[89]

Public Health (Unit of Analysis Public Hospitals; Aggregated at the Territorial Entity Level)	
Proportion of live births with low birth weight (1,000 live births)	No change
Infant mortality rate (under 1 year)	Improved
Incidence of congenital syphilis (1,000 live births)	Improved
Case fatality rate due to severe dengue fever (per 100,000 inhabitants)	Improved
Suicide attempt rate (per 100,000 inhabitants)	Improved
Incidence rate of poisoning by psychoactive substances (per 100,000 inhabitants)	Improved
Percentage of implementation of resources allocated to the territory for the Collective Intervention Plan (%)	No data
Service Quality Indicators (Unit of Analysis Public Hospitals)	
Proportion of cesarean deliveries (%)	Deteriorated
Proportion of patients hospitalized for severe dengue (%)	Deteriorated
Perinatal mortality rate (%)	Improved
Case fatality rate due to extreme maternal morbidity (%)	Improved
Patient drop-off rate in the emergency department (per 1,000 patients)	Deteriorated
Patient drop-off rate in the inpatient department (per 1,000 patients)	Deteriorated
Average waiting time for care in the emergency department for patients classified as Triage 2 (per 1,000 patients)	Improved
Average waiting time for a general medicine appointment (per 1,000 patients)	Improved
Operational Balance Indicators (Unit of Analysis Public Hospitals)	
Operating balance with collected revenue and committed expenses	Deteriorated
Operating balance with collected revenue and obligated expenses	Improved
Operating balance with recognized revenue and committed expenses	Improved
Operating balance with recognized revenue and obligated expenses	Improved
Percentage of total collections from sales of services due to operating expense obligations	Deteriorated
Human Resources Debt Indicators (Unit of Analysis Public Hospitals)	
Cumulative amount of debt with contractors (COP billion)	Deteriorated
Cumulative amount of salary debt (COP billion)	Deteriorated
Number of months owed for indirect personal services	Deteriorated
Number of months owed for payroll staff salaries	Deteriorated

Source: Prepared by the author, based on data from MSPS [https://sig.sispro.gov.co/sistemaalertashospitales/; Accessed on March 22, 2024).

Validity with respect to the PDOs

- The PI and its sub-indicators lack strong validity in the context of this PforR given the difficulties in establishing a direct attribution.
- *PDO 1 – Quality of services*: It is difficult to establish a direct attribution between the actions supported under DLI 1 and Pi sub-indicators. While regulations focusing on certification standards for IPSs providers (2019) can be expected to positively impact some of the public health and quality of care sub-indicators, it is difficult to ascertain how much. Similarly, in the case of the new accreditation standards of low-complexity hospitals (2021), the level of impact could perhaps be ascertained comparing those 132 hospitals that received TA with those that did not while controlling by hospital type. Nevertheless, this analysis would be complex and time consuming, still rendering the PI inadequate in terms of its efficiency.
- *PDO 2 – Efficiency of the health system:* The lack of a direct attribution is clear in the case of hospitals' operational equilibrium and indebtedness, as there was no action under this Program focusing on hospitals' financial performance.

Environmental and Social AP

3. **The Program was implemented in accordance with the WB's PforR Financing Policy.** The ESSA assessed the Environmental and Social Risks as low. ESSA assessed the Program's system's performance against the core principles of the PforR instrument and identified minor gaps. To address these gaps, ESSA presented a PAP, comprised of two environmental and three social actions:

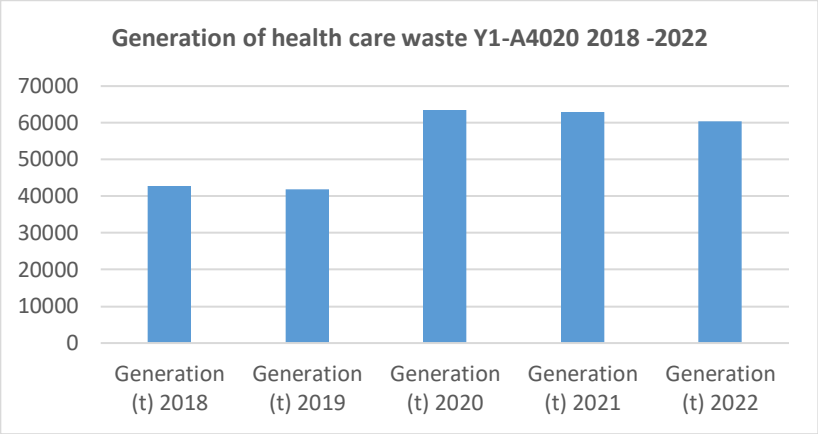
4. **Program Action 1: Monitor health IVC actions.** Completion measurement: 1) Audit reports: 2) Statistical information of waste streams by categories, discriminating waste streams for Y1 in subcategories; 3) information loaded into the Registry of Generators of Waste or Hazardous Waste (*Registro de Generadores de* Residuos o Desechos Peligrosos, RESPEL) system annually.

- PAP1 Point 1) Audit reports: Since 2021, post-pandemic, the following began to be implemented: 1) Monitoring through a Census of health care establishments and 2) Monitoring of the behavior of the "Inspection, Surveillance and Control" (IVC) in health facilities, and the internal management report of health care waste corresponding to the previous year began to be prepared by the Territorial Health Directorates (DTS). As conclusions of the implementation of the Census and IVC, the local health authorities issue the "Health Concepts" that must be addressed in order to correct them. If what is detected is of greater relevance, "sanitary measures" are issued (for example, the closure of a section to correct the non-compliance detected, or the implementation of actions to strengthen capacities). The information collected from the Censuses and the IVC was used to update the GIRASA Manual (Integrated Health Waste Management). Adopted through Resolution 591/2024, technical assistance sessions were also provided to technicians, professionals, coordinators and environmental health referents for its implementation.

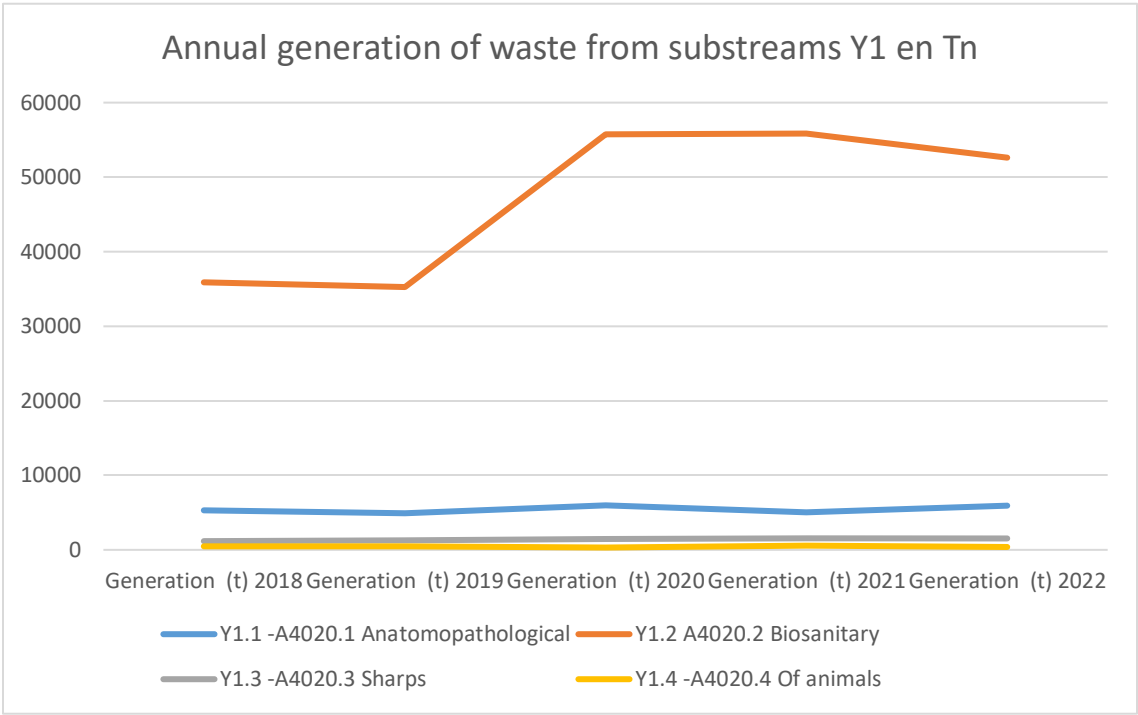
- PAP1 Point 2: Statistical information on waste streams in their categories, with Y1 waste streams broken down into subcategories.

Current waste Y1	Generation (t) 2018	Generation (t) 2019	Generation (t) 2020	Generation (t) 2021	Generation (t) 2022
Total	42731	41933	63426.5	62908	60416

[89] Reporting times at the sub-indicator level are not consistent. As an illustration, the latest public health and operational balance sub-indicators correspond to March 2024, while the majority of those for quality of care and indebtedness correspond to September 2023. Therefore, it is not clear what time period is being measured in the PI compound indicator.



Substreams	Generation (t) 2018	Generation (t) 2019	Generation (t) 2020	Generation (t) 2021	Generation (t) 2022
Anatomopathological	5277	4907	5970.6	4,993	5,920
Biosanitary	35851	35255	55729.6	55,848	52,607
Sharps	1171	1276	1415.1	1,501	1,527
Of animals	432	495	311.2	566	362
Total	**42731**	**41933**	**63426.5**	**62908**	**60416**



The most reported subcategory is biomedical waste, with 87% in 2022; followed by that of anatomopathological waste, with 10%. Although the generation of Hazardous Health Waste decreased by 4% in the last year, its generation level is still high compared to what was generated before the COVID-19 pandemic.

- PAP1 Point 3: information uploaded to the RESPEL system on an annual basis. It is important to note that the department's report the waste generated to the national authorities in arrears. Then the environmental authority reviews and consolidates the information of all the RESPELs of Colombia in the annual report that is ideally published in December of that year as official data.

    - National Report on the Generation and Management of Hazardous Waste in Colombia 2022.Publication Date December 2023
    - National Report on the Generation and Management of Hazardous Waste in Colombia 2021. Published December 2022
    - National Report on the Generation and Management of Hazardous Waste in Colombia 2020. Published December 2021
    - National Report on the Generation and Management of Hazardous Waste in Colombia 2019. Published December 2020
    - National Report on the Generation and Management of Hazardous Waste in Colombia 2018. Published December 2019
    - Respel 2017 report. Published December 2018
    - Respel 2016 report. Published December 2017

    Means of verification: https://www.ideam.gov.co/sala-de-prensa/informes/Nacional%20de%20residuos%20peligrosos

5. **Program Action 2** Promote a modification of information about the Health Care Wasted (HCW) stream that allows displaying data breakdowns making it available to the Office of Deputy Director of Environmental Health for the sub-categories: Y1.1 (pathological waste), Y1.2 (bio sanitary waste), Y1.3 (sharps waste); and Y1.4 (animal waste). To be performed jointly between MADS and the Office of Deputy Director of Environmental Health. Treatment and final disposal of HCW: Discriminate waste streams for Y1 in subcategories of this type of Y1 waste, Y1.1: pathological waste, Y1.2: bio sanitary waste, Y1.3: sharps waste, and Y1.4: animal waste. Completion measurement: 1) Minutes of agreement or similar that facilitates the access of the SSA to the functionality in the Registry of Hazardous Waste Generators for each of the sub-categories; 2) Notes or communications informing on the availability of the new functionality and the importance of its use; 3) Technical reports of conclusions.

- PAP 2 Point 1: An agreement or similar document that facilitates the Subdirectorate of Environmental Health (SSA) access to the functionality in the Hazardous Waste Generator registry for each of the subcategories. The articulation for access to the generation and destination information of RESPEL was established with IDEAM[90] by means of an Act of May 31, 2021. Based on the minutes, the SSA had access to the functionality of the Registry of Hazardous Waste Generators for each of the subcategories. As a result of the Act, IDEAM reported on the generation in advance before publication of information in the review process. Then, in 2022, it facilitated the knowledge of the access routes to the reports on waste generation and disposal of health care establishments on the IDEAM website to the SSA for the knowledge of the preliminary information until it is consolidated to make it available to the general public in the RESPEL report.

- PAP2 Point 2: Notes or communications informing of the availability and importance of using the new functionality. Based on the articulation of the MSPS and MADES, a working group was established with institutions of the health sector and environmental and sanitary authorities. Seventeen working sessions were held for the collection, consolidation, analysis and processing of information, and the guidance document for the classification and reporting of hazardous waste generated in health care and other similar activities were prepared. This was input for the dispatch of Resolution 591/2024. In addition, during 2020 and 2021, the hazardous waste policy and its

[90] Instituto de Hidrología, Meteorología y Estudios Ambientales de Colombia.

action plan were updated through a process of collective construction coordinated by the Ministry of Environment until 2030, in which the MSPS participated as a key actor.

- PAP2 Point 3: Technical reports of conclusions. After the impact of the Covid-19 Pandemic, during the years 2021 to 2023, the Census Report of waste generators of health care establishments was prepared for each year within the framework of the missionary process of inspection, surveillance and sanitary control (IVCS) (three reports), and an integrative report is in process. In addition, with the information collected, the MSPS issued Resolution 367 of 2023, which establishes the process for strengthening environmental health management at the territorial level.

- All these processes contribute to strengthening the SUISA (knowledge management system, which collects and captures the information produced by the sectors for the analysis of social and environmental determinants and their effects on the health of the population, which supports intersectoral decision-making). It is important to remember that in MSPS Resolution 3496 of 2019 it mentioned that "there are currently some difficulties in monitoring the territorial management of environmental health" as well as "The lack of sufficient information on the sectoral management of environmental health at the national and territorial level to join SUISA".

6. **Program Action 3 Indigenous People**

- AP 3.1 Indigenous peoples: (SISPI) Implement the Stakeholder participation process to move forward in the pending stages: 1) Stage II (Preparation of the Base Document, and validation of the 5th component) Between 2022 and 2024, nine (9) working groups were held with the Indigenous Health Subcommittee of the Permanent Consultation Round Table, and territorial meetings were held to adapt the guidelines developed at the national level. Agreements were signed with nine (9) indigenous organizations selected by the Permanent Roundtable for the territorial dissemination of the SISPI proposal, and inputs were obtained that will allow the updating and improvement of the guidelines supporting the SISPI decree. The final validation of the document took place at the National Indigenous Congress in October 2024.

- AP 3.2. Stage III linked to issuing the administrative act of the Ministry of Health and submission at the Permanent Coordination Workgroup (MPC). The Permanent Round Table of Consultation with the Indigenous Peoples and Organizations and the MSPS held on 21 and 22 March 2023, has agreed to modify Article 145 of Law No. 339 of 2023 (health system reform bill under discussion at the closing date of the PAP). In the second half of 2024, the Decree of the Intercultural Indigenous Health System (SISPI) will be prepared, after its territorial dissemination, and approved by the Congress of Indigenous Peoples, which represents the different indigenous peoples of Colombia. This document will be signed by the President at the end of 2025.

7. **AP 4 For NARP communities, and the Rom people -** Implement the stakeholder participation process to move forward in pending stages to achieve the guidelines, directives and guidance for proper socio-cultural adaptation and inclusion of the intercultural approach that considers their standards of care that respects their ethnic and cultural identity, forms of social organization and linguistic characteristics, without the need to create a special health system for each ethnic group.

- AP 4.1 NARP stakeholder process. Between 2022 and 2024, the MPSP agreed on a work plan to define the complementary processes necessary to harmonize the Health Technical Document at the territorial level through the implementation of 34 kilombos (ethnic organizations in and a national meeting of traditional medicine practitioners of the NARP community. In 2023, An agreement was signed with an Ethnic Council for the national dissemination of the guidelines. This allowed the preparation of a final document supporting MSPS Resolution 1964 of 2024.

- AP 4.2 Rom People stakeholder process. During 2022, the 11 workshops planned in the National Development Plan 2018-2022 were held with the authorities of the Rom people to construct and agree on the health guidelines. In

2023, the pre-consultation phase was opened with the National Commission for the Dialogue with the Roma People and the route was defined to carry out the consultation phase of the pre-consultation route of the draft law 339 of 2023 (reform of the health system) to ensure the inclusion of the guidelines of these people. At the end of 2024, the result of the consultation process was the preliminary document "Health policy guidelines with a differential approach for Roma people within the framework of the general health system". A final version is expected to be ready by the end of 2025 in order to prepare an administrative act in consultation with the Rom people.

- The actions carried out in the social PAP contributed to closing the social gaps identified in the health system in relation to access and culturally appropriate provision of health services for ethnic groups. As a result of the ongoing participation process led by the MSPS between 2022 and 2024, significant progress was made in the adoption and integration of intercultural approaches in the health system. Guidelines have been developed for the adaptation of the health service, built with the participation and agreement of the relevant communities through prior, free and informed consultation. No commitments were identified after the closing of the PAP. The MSPS will continue with the approval and implementation of the health guidelines for ethnic groups as a commitment of the high government.