

Sustainable Immunization Financing

August, 2018

BREAKING NEW GROUND



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Authors:

This report was prepared by Martha Coe and Yasmin Madan.

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ACRONYMS

BCG bacille calmette-guerin

ACEMI Asociación Colombiana de Empresas de Medicina Integral (Colombian Association of Integral Medicine Businesses)

ADRES Administradora de los Recursos del Sistema General de Seguridad (Administrator of the General Health System's Resources)

DRG diagnosis related group

DTP diphtheria tetanus pertussis

EPS Entidad Promotora de Salud (Health Promotion Entity)

FARC Fuerzas Armadas Revolucionarias de Colombia (Armed Revolutionary Force of Colombia)

FOSYGA Fondo de Solidaridad y Garantía (Solidarity and Guarantee Fund)

GDP gross domestic product

HepA hepatitis A vaccine

HepB hepatitis B vaccine

HMO health maintenance organization

HPV human papilloma virus

IPS instituciones prestadoras de servicios de salud (health provision institutions)

IPV inactivated polio vaccine

MR measles rubella vaccine

MMR measles mumps rubella vaccine

MSPS Ministerio de Salud y Protección Social (Ministry of Health and Social Protection)

NIP national immunization program

OPV oral polio vaccine

PAHO Pan-American Health Organization

PCV pneumococcal conjugate vaccine

POS Plan Obligatorio de Salud (Obligatory Health Plan)

RIAS Rutas integrals de atención en salud

Td tetanus diphtheria vaccine

Tdap tetanus diphtheria pertussis vaccine

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Executive Summary

Context

- The focus of the Colombian government is on financial coverage through the national health system with the push to reach universal health coverage. However, less than half of the population contribute to the national health system through social health insurance, requiring higher levels of investment from the government than anticipated when the system was designed.
- Along with other macroeconomic factors, high levels of migration within the country have made resource allocation and the ability to respond to local health needs difficult.
- The recent recession strained national investment in immunization. Budget allocations for immunization decreased each year between 2013-2016.

Immunization Financing and Performance

- Despite the downturn in investment in the immunization program in recent years, it has proven to be a prioritized program. The immunization program has been singled out and given its own budget line within the Ministry of Health and Social Protection, giving it great visibility and financial sustainability. During the more fruitful economic times, six new vaccines were introduced to the national program within a five-year period.
- The main source of funding for the national immunization program is general taxation, with limited inputs from the sub-national level to manage the program.
- The immunization program is financed by four major actors within the health system: The MSPS manages all procurement for the national program. Departments and municipalities are responsible for program delivery, and the Entidades Promotoras de Salud reimburse service delivery.
- Colombia's program is extensive with 22 vaccines that cover 26 different diseases, though it is often thought of as a pediatric program within the health system. Limited investment has been made in providing access to vaccines along the life-course through the national program.

Potential for innovation in program financing

- Colombia shows great interest in results-based financing for public programming. Municipalities already have a performance-based program for immunization, though the incentives are not comprehensively designed to promote performance. Other platforms exist to potentially extend results-based financing for immunization, like RIAs.
 - Precedent has been set for the utilization of innovative mechanisms that avail of additional or new sources of financing for programs. The public-private partnership-based social impact bond for jobs has been well received in the country and
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utilizes a specialized innovation fund outside of national budget allocations under the Department of Social Prosperity.

- Colombia's health system recently created a new health fund, administered by ADRES, which promotes increased levels of transparency in health financing for improved management of health resources. However, this is currently neither being used in any innovative manner to increase financing nor to ensure improved outputs for health expenditures.
 - EPS pay service delivery fees for the NIP and have leeway to procure and deliver additional vaccines outside of the NIP, but they have not yet been fully integrated into the immunization program to ensure its success.
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INTRODUCTION

Colombia has a robust immunization program with a comprehensive schedule and climbing national coverage rates, but stalled investment has limited further growth of the program's schedule as well as the financing of all desired program costs.

The current program vaccinates against 26 different diseases and has 93% coverage of children 1 year old, with projections to reach 97% by the end of 2018.¹ Investments have been made to improve program monitoring and reporting, working to further increase coverage rates. Though the economy is beginning to recover, financing for the program stalled in recent years as a result of the drop in overall macroeconomic performance. As a result, the national immunization program faces a number of challenges, including an inability to add the new vaccines that it would like to introduce, limited program budgets so that sub-national governments do not have the budget to implement all the programming activities they would like, and a reliance on Empresas Promotoras de Salud (EPS) and municipalities to add needed vaccines to supplement the national program.

This brief is part of a series funded by MSD that analyzes how countries finance their immunization programs and the risks and opportunities they face within available health financing mechanisms. The brief contains valuable information for all stakeholders interested in promoting sustainable and robust immunization programs and illustrates a variety of ways to engage in realizing this outcome.

BACKGROUND CONTEXT

ECONOMIC AND DEMOGRAPHIC IMPACTS ON THE HEALTH SYSTEM

Colombia's economy is beginning to recover from the recent recession, bringing more revenue into the national coffers and boosting investment in health, and potentially immunization. Following a sharp fall in the international prices of some of Colombia's commodities in 2014, GDP growth hit a low of 1.7% in 2017.² However, a historic peace agreement, discussions about reduced corporate taxes, rebounding commodity prices, and large infrastructure investments, are expected to boost economic recovery.³ The International Monetary Fund predicts a GDP growth rate of 2.8% for 2018 and 3.5% in 2019 – over double the 2017 rate.⁴ Investment in health over this period somewhat followed the larger macroeconomic trends, falling to a low of 5.9% of the public budget in 2015 during the recession and rising sharply in 2018 to 10.9% of the public budget as the economy began to improve – nearly a doubling of absolute investment.⁵ We can expect that as the economy continues to recover and grow, Colombia's investment in the health sector will grow as well.

¹ Interview with NIP Office

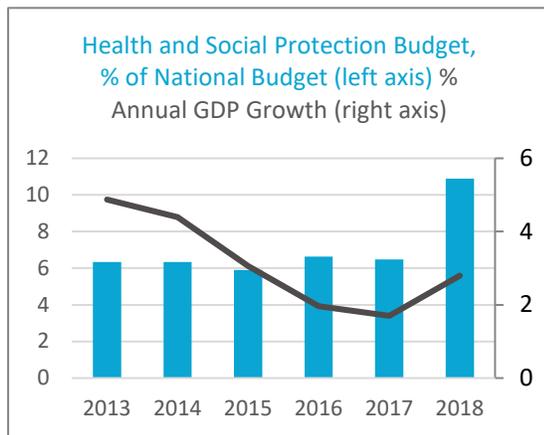
² World Bank (2018).; International Monetary Fund (January 2018).

³ OECD (May 2018).

⁴ International Monetary Fund. (January 2018).

⁵ During this time, budgets fall sharply for the Ministry of Finance, Ministry of Transport, and Ministry of Social Inclusion and Reconciliation.

Figure 1. Public Investment in Health



Source: Ministerio de Hacienda. (2018).; World Bank (2018).

Pressure on fiscal space for health is aggravated by limited individual contributions to the national health system through social health insurance. Colombia’s greater macroeconomic woes have resulted in higher unemployment rates. In 2017, 9.1% of the labor force was unemployed.⁶ This is above the regional average of 8.2%.⁷ High unemployment coincides with the reality of a large informal economy in the country. In the first quarter of 2018, the proportion of informal workers in 13 cities was 47.3%.⁸ This number is even higher in metropolitan areas, at 48.4% of the population.⁹ The public health system in Colombia relies on payroll contributions to help subsidize care for those who cannot afford it. For those that do not contribute, the government is increasingly subsidizing health insurance premiums to cover their access to services. Just under 50% of those covered by the national health system contribute to the scheme, a number much lower than the government had anticipated when creating the system.¹⁰ When macroeconomic conditions decline, so does the

⁶ World Bank (2018).

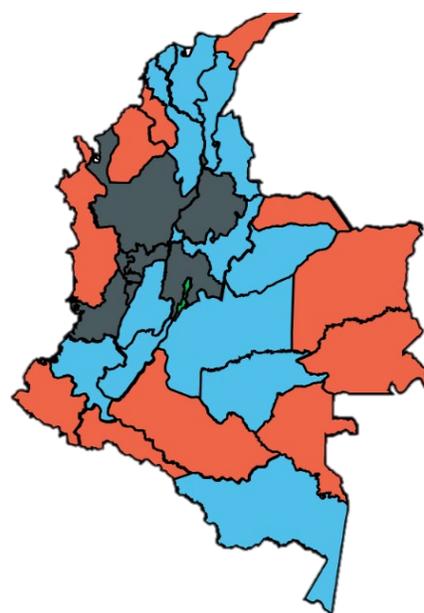
⁷ Ibid.

⁸ Departamento Administrativo Nacional de Estadística (June 2018).

government’s ability to cover those that are subsidized.

Inflated levels of migration amongst the Colombian population has created challenges in financial allocation at sub-national level as well as ability to respond to local health needs within the decentralized system. In part due to the high levels of unemployment and informality in the economy, there are high levels of migration within Colombia. In addition to the general internal movement driven by employment opportunities, the disruption in Venezuela has led to an influx of people from across the border and the historic peace agreement with FARC opened up the country to a whole segment of the population that had previously been living in

Figure 2. Subsidized Population



% of population that is subsidized

10-30% 50-80%

30-50% 80-91%

Source: Ministerio de Salud y Protección Social (January 2018).

⁹ Ibid.

¹⁰ Ministerio de Salud y Protección Social. (January 2018).

remote settings.¹¹ The decentralized nature of the country puts planning and delivery of public health service, like immunization, in the hands of the municipalities, which in turn rely on central budget transfers. The planning and budgeting for health activities relies heavily on good census data so that the central government can allocate the necessary resources to the sub-national level. The inflated internal movement and migration of populations between municipalities creates issues in appropriately financing and delivering needed healthcare services resulting in misallocated resources and systems performance issues like drop-outs in vaccination schedule, among other things.

STRUCTURES AND POLITICAL TRENDS FOR HEALTH

The Colombian health system is financed by five main actors with distinct roles. The (1) Ministry of Health and Social Protection (MSPS) is the steward of the entire system. They receive their budget from the Ministry of Finance, set sector priorities, and set in motion the financing of the system. MSPS has direct costs, provides program transfers to (2) departments (provinces) and (3) municipalities for local program management and delivery, and inputs funds into (4) ADRES. ADRES acts as the cross-subsidization fund at a national level for the multiple insurance funds in Colombia. Colombia has multiple competing insurers which are known as (5) Empresas Promotoras de Salud (EPS). The EPS function as private entities but are overseen by the MSPS. They function as health maintenance organizations (HMOs), with each EPS connected to a distinct network of public and private providers that they purchase services from. The various EPS have some coordination amongst themselves and are

managed by the Asociación Colombiana de Empresas de Medicina Integral (ACEMI) for EPS focused on contributing beneficiaries and Gestar Salud for those focused on subsidized beneficiaries. Municipalities manage public health programs and pay premiums for identified subsidized beneficiaries. They also purchase some preventive services, like immunization, from public facilities on behalf of the population that is not covered by EPS, though this is a minority of Colombians.¹²

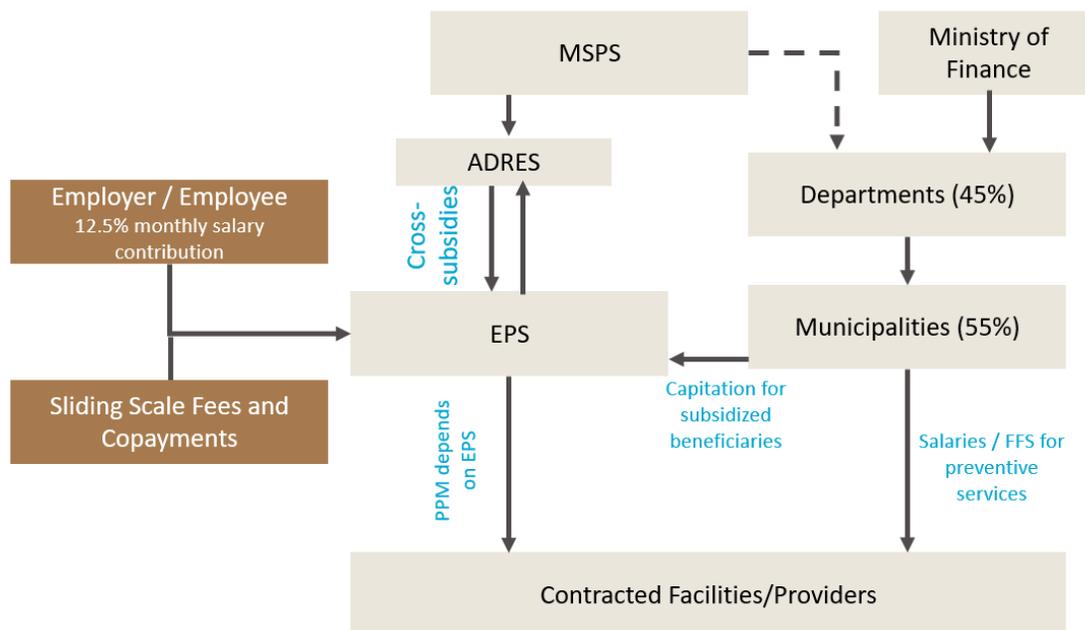
Box 1. ADRES

In August of 2017, ADRES was created from a former fund, known as FOSYGA. Where FOSYGA had multiple sub-funds and made payments to both sub-national governments and EPS, ADRES has a single fund where resources are easily tracked as they enter and exit. Increased transparency was a major factor in the government's administrative change. The MSPS puts money into the fund which is used to provide cross-subsidies to the insurance system. Individuals pay contributions monthly to their EPS, part of which is also utilized for these cross-subsidies. EPS that have surpluses in their resources from the following year make transfers to ADRES. For those EPS that had not sourced enough from contributions to cover their beneficiaries' needs, ADRES makes payments to them. All ADRES payments are now made to EPS and former payments that FOSYGA made to sub-national governments, for services like public health, are now managed by MSPS.

¹¹ Of a recent measles outbreak in 25 people across Colombia, 24 cases occurred in Venezuelan refugees, according to the NIP office.

¹² Ministerio de Salud y Protección Social. (January 2018).

Figure 3. Health System Financing Flows



Note: Central transfers for health programs are split between Departments (45% of the transfer) and Municipalities (55% of the transfer).

Inequality rates in Colombia bolster the healthcare political agenda and the national drive towards increased financial coverage and access to health services.

Inequality is a major issue and a pertinent political topic in Colombia. The health system is recognized as one of the major steps towards reducing inequality and despite a wide range in the views of the 2018 presidential candidates on other topics, all 5 candidates from the first round of elections supported further investments in strengthening the health system. Though the system is expansive, there is still a percentage of the population that is not financially covered and a number of services are still not within the benefits package.¹³ The government claims that the uncovered population is as low as 3%, though the most recently published numbers by the MSPS from September of 2017 point to this number being as high as 10%. The push to fill these gaps is holding the attention of health financing discussions.

The national health system, in efforts to increase access and promote quality of service, allows for individual choice regarding health care services. The health system in Colombia is pluralistic, where individuals are given choices concerning their insurance provider and their service provider. Though EPS usually focus on either contributing members of the system or those that are subsidized, there is some overlap. For example, members are not expelled from their EPS if they lose their job. Employers may select an EPS (which operate as private entities and can be for-profit or non-profit) for their employees, essentially choosing a network of providers and services that the employees can access, or individuals can select an EPS and associated network of choice. This decision is made based on quality, strength of the HMO network, or additional services that an EPS may provide outside of the national basic benefits

¹³ Ministerio de Salud y Protección Social. (January 2018).

Box 2. Accessing Services Outside of the Benefits Package

Colombia has an established system through which individuals can access health services outside of the explicit benefits package. The process of requesting these additional services is called a *tutela*. A *tutela* allows an individual to petition the constitutional court for their insurer to pay for a specific service. Over 90% of cases receive a ruling favorable to the patient. These ad-hoc and unexpected expenses have presented challenges to the health system where EPS go over budget and are unable to pay providers for delivering these additional services.

A new piece of technology being used by ACEMI members (the association for contributory-focused EPS) allows for greater insight into what services patients are requesting and what is being delivered. The tool also allows patients to directly request the EPS for additional services, often granted with a doctor's recommendation. Implemented in February of 2017, the tool has cut down on *tutelas* and allowed EPS to have better insight into their expenses and beneficiaries' needs

Source: Interview with ACEMI

package (Plan de Beneficios en Salud – PBS), as defined by the MSPS. The MSPS has begun to communicate health outputs associated with individual EPS to further promote this factor in EPS selection.

Though access has been the focus of the system, inefficiencies and disincentives that have resulted in financing pressures have both the government and EPS considering new financial mechanisms to improve quality. Capitation is the provider payment mechanism for primary care, and provider payments for inpatient care depends on the EPS.¹⁴ A mixture of global budgets, fee-for-service, case-based payments, and other performance-based mechanisms are used within Colombia, depending on the EPS. Though EPS are bringing in more money from both contributions and government subsidies, they have been losing money in recent years.¹⁵ Issues of corruption persist and the utilization of services outside of the guaranteed benefits package that the EPS can be legally obliged to fully cover has strained the system's finances. The newly elected president, Ivan Duque, has spoken an interest in finding efficiencies through endorsing prevention and promotion services and aligning health service payments with results. Colombia has already

experimented to an extent with results-based financing through its Cuenta de Alto Costo mechanism.¹⁶ This fund provides financial incentives to the EPS for the appropriate care and treatment of a number of high-cost diseases, including diabetes, cancer, HIV, and chronic renal disease. Cuenta de Alto Costo and ACEMI have shown interest in expanding the use of this type of performance-based mechanism to incentivize further health outputs and outcomes. The expansion of the Rutas Integradas de Atención (RIAS) system, which provides comprehensive service guidelines for the promotion and maintenance of health, could provide a timely platform to do this.¹⁷ RIAS includes built-in processes to care provision that could translate well into indicators to be used in a new performance-based financing mechanism. Following the processes could potentially promote efficiencies, the increased delivery of vaccines as a preventive process in the care of specific services, like HPV vaccination or HepB vaccination, and improved health outputs in the Colombian health system.

¹⁴ OECD (2016).; Duran-Valverde (2014).

¹⁵ OECD (2016).

¹⁶ Ministerio de Salud y Protección Social (2018b).

¹⁷ Ministerio de Salud y Protección Social (2018c).

THE NATIONAL IMMUNIZATION PROGRAM IN COLOMBIA

Program Snapshot

Colombia’s program is extensive with 22 vaccines that cover 26 different diseases.

The vaccine schedule in Colombia is in line with the region, but globally it is quite comprehensive. Despite the extensive schedule, Colombia is limited in the vaccines available to adults within the national program. The national immunization program (NIP) is mainly treated as a program for children and adolescents, with vaccines available further along the life-course, like pneumococcal, Hepatitis B, and shingles, left off of the NIP. These vaccines require additional resources from EPS and municipalities in order to provide them to their populations.

The Santos administration displayed great support for the immunization program with six vaccines added to the schedule. The political support that occurred during times of strong economic performance resulted in multiple new vaccine adoptions over the past 8 years (PCV in 2011, HPV in 2012, HepA and Tdap in 2013, and IPV and Varicella in 2015). Colombia also developed a National Immunization Technical Advisory Group during this time, allowing for greater use of data and expert opinion in vaccine introductions. To add a new vaccine now, the NIP team conducts a cost effectiveness study which is analyzed by the technical advisory group for recommendation to the MSPS.

Figure 4. Number of Vaccines on National Schedule



Source: WHO (2018b).

If agreed to, the MSPS submits a budget proposal to the Ministry of Hacienda (Colombia’s Ministry of Finance) for procurement and program delivery costs. Since 2015, during slow economic growth, the program’s growth has also slowed as budgets become more inflexible. Despite the request for the routine delivery of the meningococcal vaccine, the Ministry of Hacienda has not made the budget available. With the new administration, it is unclear whether budget for introducing new vaccines will be prioritized in the midst of health resources continuing to be directed towards expanding coverage under the national health system, primarily through ensuring that all Colombians have an affiliation to an EPS.

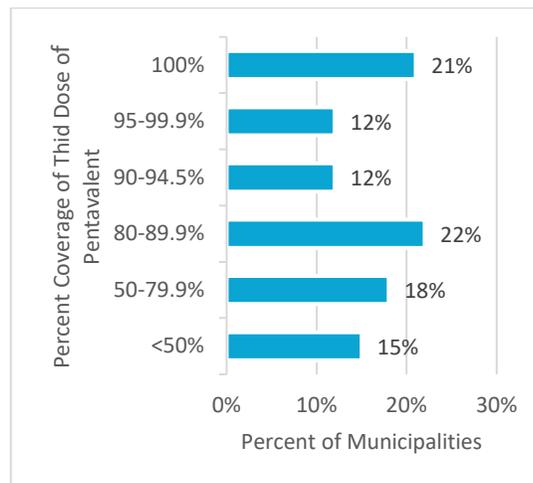
Figure 5. Vaccines in the NIP

BCG
DT
DTP
DTP-Hib-HepB
HepA Adult
HepA Pediatric
HepB Pediatric
HPV
Influenza Adult
Influenza Pediatric
IPV
MenACWY-135
MMR
MR
OPV
PCV
Rabies
Rotavirus
Td
Tdap
Varicella
Yellow Fever

Pediatric Vaccine
Adolescent Vaccine
Lifespan Vaccine
Source: WHO (2018b).

The MSPS has made concerted efforts with local governments in recent years to raise coverage rates of the vaccines in their program. Though there have been some vaccine confidence issues in relation to the HPV vaccine, the immunization program is generally well accepted. The expansion of the health insurance system has only benefited immunization. Insured children are 6% more likely to be vaccinated.¹⁸ In rural areas this number rises to 12% more likely.¹⁹ The study suggests that increased exposure to, and utilization of, the health system improves vaccination outcomes. Despite these positive outputs and relatively high national coverage rates, municipal coverage rates vary widely. 15% of municipalities had less than 50% coverage of the pentavalent vaccine in 2016 with numbers as low as 11.1%.²⁰ Newer vaccines have similar ranges in coverage. Though the varicella vaccine had a 91.2% coverage rate in 2016, some municipalities fell as low as 11.8% coverage.²¹ It must be noted that heavy migration amongst the population makes analyzing municipal-level data difficult, but a national tracking system is being rolled-out currently to make data analysis easier. At 90% installed, the NIP team at the MSPS hopes it will ease data and surveillance challenges.²² Data is also sorted by EPS affiliation so that some level of political accountability for these actors is in place. A recent report on immunization

Figure 6. Pentavalent Coverage Rates by Proportion of Municipalities, 2016



Source: Ministerio de Salud y Protección Social (2018a).

coverage in Colombia revealed that 2 EPS had scores lower than their competitors. Though there is no financial penalty for this, unless the market reacts to the quality standards, the government did meet with both EPS to discuss the situation.

Program Financing

Sources and Pools of Financing

Funds for the public immunization program are sourced through 3 main actors: the MSPS, municipalities, and the EPS. While the majority of financing is sourced from general taxation allocations to the MSPS at the central level and transferred through

Box 3. Vaccination Without Borders

One mechanism, through which Colombia has expanded access and increased equity of its immunization program, is an open access for all program known as “Vacunación sin Fronteras”, or “Vaccination without Borders”. Though individuals are usually beholden to their primary facility through their HMO, or the local public facility if uninsured, anyone can walk into any health facility and get vaccinated for free. Local governments and EPS across Colombia take part in this program and arrange the necessary payments for their beneficiaries. The program is one of the interventions the country implemented to improve dropping coverage rates that coincided with the global recession.

¹⁸ Glassman et al (2009).

¹⁹ Glassman et al (2009).

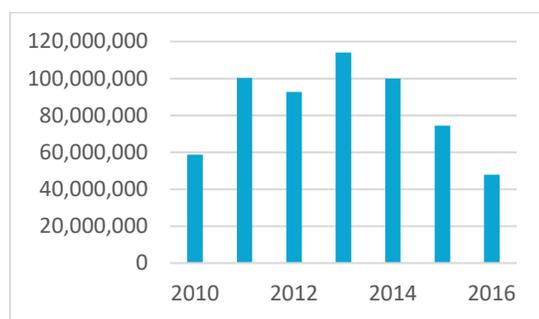
²⁰ Ministerio de Salud y Protección Social (2018a).

²¹ Ibid.

²² Interview with NIP Office

program budgets, municipalities do mix in some local resources from tobacco and alcohol taxes, car insurance payments, and some other earmarks.²³ The tax on tobacco brought US\$250 billion into the health system in 2017 and the tax on alcohol sourced an additional US\$500 billion.²⁴ The utilization of local resources ranged from 12-80% of local health budgets in 2005 with most municipalities relying heavily on transfers from the central government.²⁵ According to self-reporting numbers, Colombia reached its peak budget in 2013, prior to the economic downturn, with over US\$114 million spent on immunization.²⁶ The budget then fell each year reaching a low of US\$47,854,084.²⁷ We can assume with the upturn in health allocations in 2018, the immunization budget also received a bump, though those numbers are not yet public. A major challenge to the sustainable financing of immunization in Colombia is the inconsistent budgeting. Though immunization law 1373/2010 requires the government to take the necessary budget provisions to deliver free immunizations to the infant population, it is not an expansive or detailed piece of legislation that has teeth during the budgeting process and it is devoid of reference to the adolescent and adult populations that also benefit from the NIP.²⁸

Figure 7. Government Expenditure on Routine Immunization (US\$)



²³ Ministerio de Salud y Protección Social (February, 2017).

²⁴ Ibid.

²⁵ Ramirez et al (2014).

²⁶ WHO (2018a).

²⁷ Ibid.

Source: WHO (2018a).

Though the MSPS is the major source of program funding through general tax provisions, responsibility for program delivery is shared amongst multiple actors at the decentralized level.

Under Law 715, the Ministry of Finance makes block transfers to both departments and municipalities with limited requirements attached.²⁹ These transfers do not have line-items attached, but they are broken into semi-specific activities. One activity is for collective interventions, or public health programs. The national immunization program falls under this budget. The calculation of these transfers is usually done based on population size, not local need. Of the sub-national transfers for immunization, 55% goes to municipalities and 45% of the centrally transferred funds go to departments.³⁰ These entities have autonomy over how the funds are spent, under Law 715 (2001), but the collective intervention funds must be used, in part, to deliver the immunization program.³¹ As a result of the high level of decentralization in the system, even though the MSPS and the NIP office within the MSPS are strong program advocates, their influence for program expenditures is somewhat limited.

Immunization Expenditures

Despite cuts in funding during the recession, the immunization program has been prioritized under recent administrations with increasing visibility and access to vaccines.

Since the administration of Alvaro Uribe (2002-2010), the immunization program has been singled out and given its own budget line within the MSPS. It no longer falls under the prevention and promotion office, giving it great visibility and financial sustainability. Additionally,

²⁸ El Congreso de Colombia (January 8, 2010).

²⁹ El Congreso de Colombia (December 21, 2001).

³⁰ Ministerio de Salud y Protección Social: Dirección de Financiamiento Sectorial. (June 2016).

³¹ El Congreso de Colombia (December 21, 2001).

under the administration of Juan Manuel Santos (2010-2018), six new vaccines were introduced to the national program. While the economy was performing strongly in the early years of the administration, funds were available and allocated for these additions. Since the economic slow-down of recent years, the immunization program has felt the pressure and the budget has become quite inflexible. Though the NIP office would like to add the meningococcal vaccine to the national schedule, the funds have not been made available for its routine procurement. To get around this budget issue, the office has used the outbreak budget to procure and stock the vaccine for potential need. The budget squeeze is mainly felt in the program’s management and administration. Once a vaccine is on the schedule, it is extremely precarious, politically, to suspend procurement so budget cuts are placed on program costs. During times of limited liquidity, the government receives advances from PAHO, allowing for payments for vaccines over time rather than up-front payments. The government previously received a grant from the IDB for the immunization program in 2005, but the NIP no longer pursues donor funding for the program as it is seen as a reason for national budget writers to cut program allocations.³² For program delivery, transfers still continue to flow to sub-national governments, though the transfers are no longer given in one block, but rather multiple tranches throughout the year.

Table 1. Public Health System Actors and their Roles in the Immunization Program

MSPS	complements activities as needed. Procures and distributes vaccines and supplies for implementation. Sets norms and policies, provides TA to sub-national governments
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Departmental health directorates	carry out complementary activities: supervision, technical assistance, disease surveillance, and coverage reporting
Municipal health directorates	provide care, pay vaccinators, ensure supplies reach providers, coverage monitoring and reporting, conducting campaigns
EPS	responsible for providing vaccinations to insured residents
National Health Institute	responsible for disease surveillance

The MSPS procures all vaccines for the NIP. Colombia uses the PAHO Revolving Fund to procure vaccines for its low prices and ease of use, rather than negotiating prices with multiple manufacturers. Though the NIP program office within the MSPS conducts procurement method cost studies for each vaccine, they have always found the Revolving Fund to be more cost-effective for procurement. Additionally, high performance on coverage opens up opportunities for municipalities to consider procuring supplementary vaccines for their local program and EPS can also add additional vaccines or cohorts to their benefits packages. While this option is available, it is not often utilized. Both of these actors see that the NIP is comprehensive and perceive minimal benefit of extended access to non-NIP vaccines for their beneficiaries. Still, should additional procurements be pursued, they are still managed by the MSPS and done through the Revolving Fund with budget supplied by the municipality or EPS.

While NIP delivery is the responsibility of the municipalities, the majority of health services are purchased by the EPS. Public health services, like immunization, are available to all and reimbursed through the

³² Glassman et al (2004).

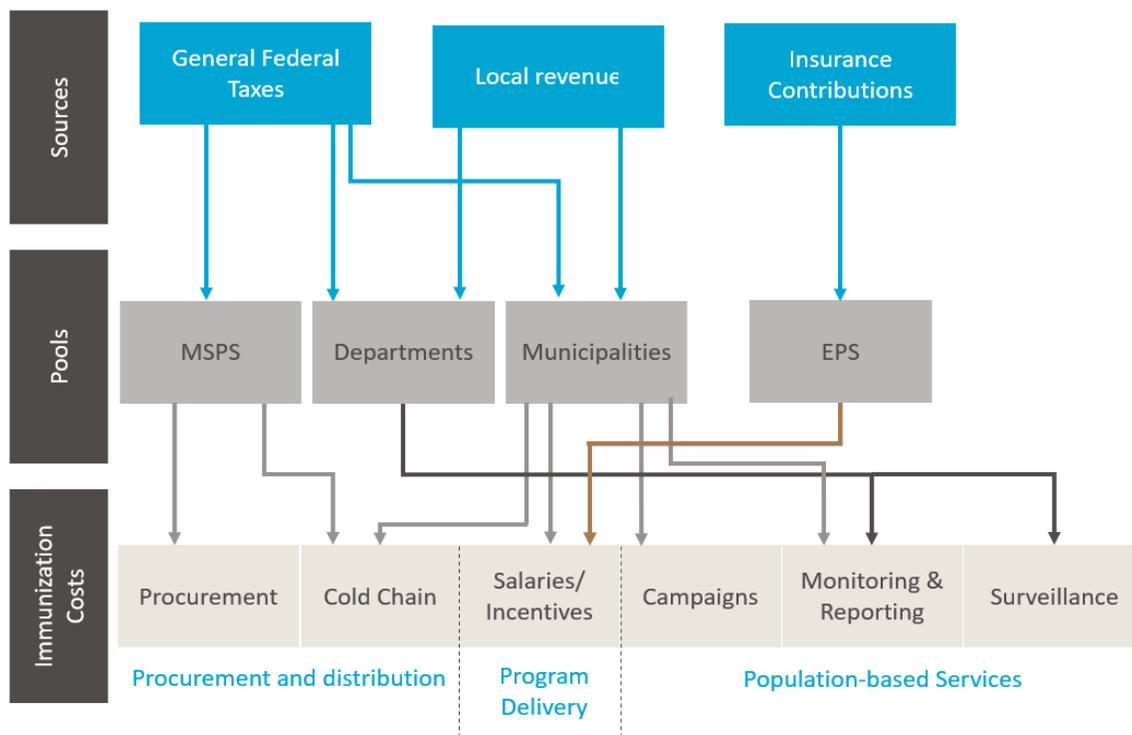


Figure 8. Colombia National Immunization Program Funding Flow

EPS. Insurance funds (contributions mixed with public subsidies) are utilized to reimburse immunization delivery for beneficiaries. While facilities are generally paid for primary care with capitation payments, vaccinations add an additional fee for service payment. Still, 3% of the population is not covered by the national insurance system.³³ This is one area where municipal health secretariats play an important role. For those without insurance coverage, municipalities have a local, public entity that acts like an EPS which reimburses facilities for the delivery of vaccines. It provides no financial coverage for other services within the national benefits package. Municipalities hold responsibility to deliver the NIP to both insured and uninsured individuals. If coverage rates in a municipality reach 95%, they are eligible for a 10% bonus payment in the public health budget transfer from the MSPS the following year. In previous years, Bogotá has received

this bonus, but receiving their budget in tranches due to macroeconomic effects on the national budget has limited the impact and visibility of such a bonus for the municipality.

Other population-based services are split between departments and municipalities. Municipalities use their central budget transfers for public provider salaries, public facility infrastructure, public health interventions (water, sanitation, immunization, etc.). This includes distribution logistics for public facilities, campaigns (including school-based programming), communication strategies, monitoring and reporting, and service delivery fees for the uninsured. Departments support municipalities in certain aspects of the system, including disease surveillance, but the majority of the health system is managed by the municipalities. Surveillance

³³ Interview with NIP Office; Interview with Bogota Health Secretariat

data is shared up from municipalities, to departments, and held at the National Health Institute. The national immunization program also used to benefit from some financing from the national health fund (FOSYGA), but the recent change in administration of this fund to ADRES in August of 2017 erased this line of funding which was absorbed into the MSPS transfers.

Ongoing Challenges for the Current Program

- 1. Stalled National Investment** – As macroeconomic growth in Colombia stalled from 2014 – 2017, so did investment in the immunization program. From 2013 to 2016 the immunization budget fell by over US\$60 million.³⁴ The strong foundation of the immunization program, and a reinvigorated push to increase insurance coverage has left limited interest in addressing the program and a relatively inflexible budget line. Other avenues for financing the program beyond general taxation allocations are limited. This has not only been challenging for the NIP program's expenditures (payments, both for vaccines, and to municipalities are now made in tranches rather than up front), but has stopped expansion of the program, despite needed vaccines remaining outside of the schedule. The NIP would like to add meningococcal to the routine schedule but is left procuring these vaccines with outbreak program funds. To expand the necessary investment in the immunization program, Colombia will need to find some innovative mechanisms to increase finances as the government, continuing to recover from its recession, focuses its resources on increasing access to and coverage of the national insurance program.
- 2. Sub-National Resources** – Though immunization program financing has been stable in recent years, there is not enough financing to complete all desired activities. There is also a great variance in immunization coverage performance across municipalities. Bogotá, one of the richer areas that puts in local resources to health, is unable to finance a year-long communications strategy to remind people to get immunized and fight any vaccine hesitancy issues. Other municipalities' challenges are more pronounced with coverage rates of DTP3 as low as 11.1% recorded in parts of the Amazonas department in 2016.³⁵ Fiscal space challenges could be addressed at the sub-national level to an extent, where limited funds are currently sourced, less are allocated to health, and poor resource tracking and varied performance suggest inefficiencies in program expenditures.
- 3. Prioritization of Adult Vaccines** – Colombia's NIP is largely considered a pediatric program. A few vaccines along the lifespan are included in the national schedule, but of the vaccines that are missing, the majority are for adults. Because vaccines are such a cost-effective intervention, this often leaves municipalities and EPS to finance these adult vaccines if cost-effective for their beneficiary pool. For Colombia, a country very interested in increasing equity amongst its population, these ad-hoc interventions are an issue. Colombia should explore ways that leverage interest and resources from sub-national and EPS actors in a more equitable way.
- 4. Migration** – A high level of internal migration has been an ongoing challenge for the Colombian immunization program. The central government and

³⁴ WHO (2018a).

³⁵ Ministerio de Salud y Protección Social (2018a).

municipalities have difficulties determining what resources are needed where to achieve high performance on program coverage. On top of resourcing issues, municipalities are unable to track their population to ensure that vaccination schedules are followed and that multiple-dose vaccines are

delivered properly. To combat this issue, the ministry is rolling out a new national reporting system that works both online and offline so that governments at all levels have access to more in-time information.

IMMUNIZATION FINANCING IN TRANSITION: OPTIONS FOR INCREASED FINANCING AND SUSTAINABILITY

MSPS and immunization

The Ministry, as well as the larger government, have put a lot of support behind the growth of the national health system, but in recent years the immunization program has been left to the side as focus shifts towards increased financial protection for the population. Engaging the NIP office in the MSPS will be critical for any sustainable immunization financing engagement. The program receives a lot of visibility at the national level, yet it does not yet have a guaranteed budget. Potential for innovation is also on the table. The Department of Social Prosperity recently launched the first social impact bond focused on employment to positive reviews. Their utilization of public-private partnerships and an “innovation fund” could provide good learnings for immunization financing opportunities.

Table 2. Leveraging the MSPS for immunization financing

Pros:

- Health is a prioritized sector with good standing in regards to absorptive capacity
- NIP office has a lot of visibility
- Precedent for “innovation funds” outside of sector budgets that can work with private finance
- Positive attention being given to Department of Social Prosperity for its social impact bond

Cons:

- Immunization program budget at the central level fluctuates to a large degree with the larger national budget
- The National Immunization Program’s growth has been very inflexible over the past couple of years despite interest from the NIP office
- Program costs are carried out by other actors with limited accountability to MSPS

Opportunities

- Innovative Financing to address how to open up fiscal space to add new vaccines that the NIP office is interested in
 - Potential guaranteed NIP budget (line-item) to cover all program expenses
 - Tailor performance incentives for municipalities to have greater impact
-

Municipalities and immunization

Municipalities play a large role in the delivery of the immunization program and must be engaged if any new funds are to be utilized for strong system performance. The autonomy that municipal offices hold over their budgets gives them great power of immunization budgets. However, there are 1,122 municipalities in Colombia and it would be near impossible to deliver sustainable immunization financing by engaging each one individually,

especially as they are not major sources of funding. More promising engagements could include piloting interventions for non-NIP vaccines at the municipal level or working with overarching actors, like the MSPS or EPS, to create accountability lines to multiple municipalities.

Table 3. Leveraging Municipalities for Sustainable Immunization Financing

Pros:

- Autonomy in how program funds are spent
 - Incentive structure already in place with MSPS for immunization outputs
-

Cons:

- Reliant on central budget transfers
 - Great variability in capacity to resource and fund programs
 - Limited accountability for outputs
-

Opportunities:

- Coordinate with EPS to improve equity within sub-national localities
 - Expanded results-based financing contracts with the national government with clear connections to performance bonuses or penalties depending on prioritized objectives
 - New local revenue generation for needed communication and campaigning activities (traditional or innovative)
-

EPS and immunization

The EPS are the major purchasers of immunization services and, as quasi-public entities, are more likely to engage in innovative opportunities. ACEMI, the guild to which 10 major EPS that cover 22 million people belong, is very interested in results-based financing and other potential innovations that could increase efficiencies, promote quality care, and bring additional funds into the system. The issue with approaching an individual EPS lies with equity concerns. A quick win with one purchaser does not create sustainable financing, but limits access to a new service. Interventions in this space must be handled with care to as to promote sustainable immunization financing for Colombia as a whole, and not just one pool of beneficiaries.

Table 4. Leveraging the EPS for Sustainable Immunization Financing

Pros:

- New national presidential administration interested in results-based financing
 - ACEMI very interested in innovative financing ideas
 - ACEMI pursuing results-based financing opportunities
-

Cons:

- Multitude of pools creates equity concerns for ad-hoc interventions
- Additional vaccines dependent on engaging with each individual EPS

Opportunities:

- Co-payments for additional vaccines available in more EPS
- Connect ADRES transfers to performance. Draw from experience from Cuenta de Alto Costo
- New lines of encouragement/reward for performance of EPS beneficiary coverage rates and/or expanded schedules
- Public-private partnership with local governments to encourage expanded schedules (focus on increasing access across population segments)

ADRES

ADRES does not finance immunization. Since FOSYGA was eliminated, public health funds are no longer pooled under the cross-subsidization fund, but under MSPS. However, it is a fund that is financing the health system in a very traditional way. Money is put in, money is transferred out. Potential opportunities do exist to engage ADRES's fund of resources in a more innovative way that increases finances, opens fiscal space for health, and thus potentially increases fiscal space for immunization.

Table 5. Leveraging ADRES for Sustainable Immunization Financing

Pros:

- Large pool of funding in place
- Transparent governance in place

Cons:

- The pool of funds is no longer associated with public health or immunization
- Administration is set up for cross-subsidization and transparency, not for resource generation

Opportunities:

- Transform fund as a resourcing mechanism (e.g. a trust fund)
-

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