Contributions to the transformation of the Colombian health system*

Aportes para la transformación del sistema de salud colombiano

Contribuições para a transformação do sistema de saúde colombiano

Blanca Myriam Chávez Guerrero[1]

[1] Doctora en Salud Pública, Universidad de Antioquia, Medellín, Colombia. blanca.chavez@udea.edu.co. ORCID: https://orcid.org/0000-0002-3238-901X

Recibido: 04/12/2021. Aprobado: 25/10/2022. Traducción publicada: 21/04/2023

Chávez BM. Contributions to the transformation of the Colombian health system. Rev. Fac. Nac. Salud Pública. 2023;41(1):e348269. DOI: https://doi.org/10.17533/udea.rfnsp.e348269

Abstract

The objective of this essay is to contribute elements to the debate on the crisis of the General System of Social Security in Health of Colombia, the fundamental right to health and its implications, and thus to propose other elements for the new health system required by this country, without this essay constituting a reform project. The result of the analysis shows that Law 100 of 1993 not only deepened inequities, but also generated new avoidable and regressive inequalities, such as the lack of comprehensive care, the deterioration of public health, placing financial profitability above the rights of the people, the denial of services, inadequate Government regulation and the corruption of the majority of its actors. The amendments to said law (Laws 1122 of 2007 and 1438 of 2011) and the promulgation of the fundamental right to health in Law 1751 of 2015 has not achieved significant changes in the health system, despite the issuance of hopeful new regulatory norms, given that the current system is based on neoliberalism. Health is a product of social action and not a mere result of medical care. Consequently, the right to health must go beyond illness to wellbeing, as a guarantee provided by the Government. The foundation of a new health system will undoubtedly be human dignity in its objective and subjective elements, as the highest expression of compliance with human rights.

---------*Keywords:* right to health, dignity, Government, Law 100 of 1993, neoliberalism, health system

* Esta versión es una traducción del artículo *Aportes para la transformación del sistema de salud colombiano* publicado en la Revsita Facultad Nacional de Salud Pública https://revistas.udea.edu.co/index.php/fnsp/article/view/348269

Resumen

El objetivo de este ensayo es aportar elementos para el debate sobre la crisis del Sistema General de Seguridad Social en Salud de Colombia, el derecho fundamental a la salud y sus implicaciones y, asimismo, proponer otros elementos para el nuevo sistema de salud que requiere el país, sin que se constituya este ensayo en un proyecto de reforma. El resultado del análisis muestra que la Ley 100 de 1993 no solo profundizó las inequidades, sino que además generó nuevas desigualdades evitables y regresivas, como la carencia de atención integral, el deterioro de la salud pública, la rentabilidad financiera por encima de los derechos de las personas, la negación de los servicios, la inadecuada regulación del Estado y la corrupción de la mayoría de sus actores. Las reformas a dicha ley, mediante las leyes 1122 de 2007 y 1438 de 2011, y la promulgación del derecho fundamental a la salud en la Ley 1751 de 2015, no han logrado cambios significativos en el sistema de salud, a pesar de la emisión de nuevas normas regulatorias esperanzadoras, dado que el sistema actual se basa en el neoliberalismo. La salud es producto de la acción social y no un mero resultado de la atención médica; en consecuencia, el derecho a la salud debe transcender de la enfermedad al bienestar, como garantía proporcionada por el Estado. La base de un nuevo sistema de salud será, sin duda, la dignidad humana en sus elementos objetivos y subjetivos, como máxima expresión del cumplimiento de los derechos humanos.

---------*Palabras clave:* derecho a la salud, dignidad, Estado, Ley 100 de 1993, neoliberalismo, sistema de salud

Resumo

O objetivo deste ensaio é fornecer elementos para o debate sobre a crise do Sistema Geral de Segurança Social em Saúde da Colômbia, o direito fundamental à saúde e suas implicações e, igualmente, propor outros elementos para o novo sistema de saúde que o país requer, sem que este ensaio comporte um projeto de reforma. O resultado da análise mostra que a Lei 100 de 1993 não só aprofundou as assimetrias, mas gerou novas desigualdades evitáveis e regressivas, como a ausência de atenção integral, a degradação da saúde pública, a rentabilidade financeira por cima dos direitos das pessoas, a negação dos serviços, a inadequada regulação do Estado e a corrupção da maioria de seus atores. As reformas de tal lei, por meio das leis 1122 de 2007 e 1438 de 2011, e a promulgação do direito fundamental à saúde na Lei 1751 de 2015, não atingiram câmbios significativos no sistema de saúde, apesar da emissão de novas normas regulatórias esperançosas, pois o sistema atual se baseia no neoliberalismo. A saúde é produto da ação social e não um mero resultado da atenção médica; em consequência, o direito à saúde deve transcender da doença para o bem-estar, como garantia providenciada pelo Estado. A base de um novo sistema de saúde será, sem dúvida, a dignidade humana em seus elementos objetivos e subjetivos, como máxima expressão do cumprimento dos direitos humanos.

---------Keywords: direito a saúde, dignidade, Estado, Lei 100 de 1993 neoliberalismo, sistema de saúde

Introduction

The objective of this essay is to provide elements for the creation of a new health system for Colombia, with the participation of social, political, economic, and governmental actors who will lead to the materialization of the right to health through a new system that responds to the needs of the country. The scope of this essay is to address critical issues of the current health system and the aspects that should be included for building a new one. Therefore, it is not a transformation project, nor does it set out routes to develop it.

The subject at hand is presented through 1) the crisis of the General System of Social Security in Health, which has occurred during its operation since the enactment of Law 100 of 1993; 2) declarations on the fundamental right to health and the implications for its materialization; and 3) the theoretical contribution for a new health system structure. As a starting point, I conducted a non-systematic review of the literature in indexed journals; bulletins, laws, and regulations of the Ministry of Health; declarations of national and international organizations; studies; and unpublished literature.

Crisis of the General System of Social Security in Health

The model implemented through Law 100 of 1993 [1] is based on the modification of the relationship between the Government and society. It is also based on the principle of distributive justice on which the Government relies to define health as a consumer good, which gives way to regulated competition in the provision of health services [2,3].

Without losing sight of the neoliberal foundation of the Colombian General System of Social Security in Health (Sistema General de Seguridad Social en Salud, SGSSS), some actors [4-6] recognize that there are positive aspects, such as the Solidarity and Guarantee Fund, where all resources converge; the requirement of a minimum benefit plan; compulsory insurance; the capitation payment unit; separation of administrative functions; and provision of services. In addition, the coexistence of the contributory and subsidized regimes should also be highlighted, the latter aimed at the poor, who are targeted through a survey that examines a combination of criteria for determining the poverty line and unsatisfied basic needs [3].

In the previous regulations, the Ministry of Health and Social Protection issued Press Release 186 of 2012 [7] and more recently, Resolution 0002292 of 2021 [8], which underlines the unification of health plans. However, the intentions of the health authorities are yet to be materialized, continuing with the system's restrictions. All that can be shown is the advancement in the insurance of the population, which has reached 99.6% [9]. This percentage means that people are enrolled and that the health-promoting entities (Entidades Promotoras de Salud, EPS) have money for health care in the same proportion, but this does not reflect the health coverage of the population.

Seemingly, Law 100 of 1993 [1] would correct the deficiencies of the previous National Health System of 1975. However, when the model was implemented, many problems arose, such as the inability to govern it; the insurance companies undertaking the leadership role in accordance with their interests and in the absence of the Government; low coverage of services; duplication of enrollment in the regimes due to the lack of an information system; internal corruption; increased public and private spending on health due to intermediation; the multiplicity, duplicity, and ambiguity of the regulations issued by the Government; and the denial of services, which have led to multiple writs for the protection of fundamental rights.

The SGSSS has been unable to solve the structural problems in health care, which create inequalities in the population by linking the health system to people's ability to pay [1,10]. This model has complex regulatory mechanisms that conceal a serious problem by conceiving health as a service for individual consumption that can be solved by the market [11], thus creating inequities and violating the fundamental right to health.

The critical situations of the SGSSS have been observable and verifiable throughout its entire operation, accumulating multiple failures. The most noticeable issues, studied by different authors and researchers who focus on the crisis of the system, are the lack of comprehensive, differentiated, timely, and quality care for the majority of Colombians. This is due to multiple problems, such as the fragmentation of services and the

structural segmentation of the system; poor information and communication; deferred authorizations; delay in appointments with general practitioners and specialists, as well as in diagnostic testing, surgical procedures, treatment, and medication dispensing; and enrollment inconsistencies, directly affecting the population that is most in need [12-15]. Moreover, financial profitability has been prioritized above people's rights. An example of this is the systematic profit-driven refusal of services that are included in the health benefits plan. This has resulted in the diversion of resources, to the detriment of the care of diseases prevalent in the majority of the population, without any acknowledgment from the governing bodies.

The above issues led to the filing of approximately four writs for the protection of fundamental rights per minute due to failure or denial of health services, with the involvement of the National Superintendence of Health and the Ministry of Health, for not controlling and sanctioning the responsible parties. In addition, vertical integration—which allowed insurers to provide health services directly and with their own centers—legally facilitated the extraction of money from the system and the liberalization of drug prices, which led Colombia to pay for the most expensive drugs in the world for a long time [9,16-19].

There has also been a negative impact on health due to the deepening of unfair and avoidable inequalities, negatively affecting the country's most vulnerable population. This has resulted in higher rates of infant and maternal mortality compared to the previous system, low vaccination coverage that does not reach useful levels of prevention, high levels of malnutrition, and increased morbidity and mortality due to tropical diseases and congenital syphilis. These issues have shown different results in the contributory and subsidized regimes and are seemingly not visible for the Ministry of Health and the Government. Another effect was the shutdown of pediatric and maternity services and, for financial convenience, the use of more complex technologies than what is required, such as the practice of cesarean sections replacing natural childbirth [20-22].

Public health has been the most affected by Law 100. Its continuous and systematic deterioration has allowed a rise in preventable diseases, resulting in the use of complex and costly technologies for diagnosis, treatment, and rehabilitation, which often produce avoidable complications and deaths in the population.

Health promotion and disease prevention became a commonplace expression known as "P & P," disregarding previous advances in health care and separating the Government from the covenants, declarations, and guidelines of international health organizations (Pan

American Health Organization—PAHO, World Health Organization—WHO). These commitments were made by the Colombian Government, but were not fulfilled [23,24]. Public health actions that promote, preserve, and protect health, with high collective impact and high externalities, were not favored due to their low economic profitability and an ideology centered on neoliberal individualism. This has led to an increase in the number of communicable diseases that had been under control in the past (cholera, dengue hemorrhagic fever, and vaccine-preventable diseases) [19,25-29].

The transformation of public hospitals into state-*owned social enterprises* led to the liquidation or closure of many of them, forcing them to compete in the market with tools typical of the private sector, e.g., invoicing each activity, outsourcing employment, and hiring personnel through cooperatives, to the detriment of working conditions [30-33]. These neoliberal-leaning institutional arrangements guaranteed free competition and the commodification of health, with new actors, roles, and processes. The health promotion entities (EPSes) control the allocated funds and establish contracts with service-providing institutions, forcing them to generate financial profitability, at the expense of social welfare. Intermediaries control the flow of financial resources and withhold payments, sometimes without explanation, which has caused hospital crises due to a lack of liquidity for them to operate. In addition, the intermediaries lack transparency and accountability reporting, resulting in a deplorable use of the system's resources [17,34,35].

Corruption has permeated the entire system, manifesting itself in different ways. The insurance model supported by the conditions of the single health benefits plan and the capitation payment unit (UPC) made it easier for the EPSes to group together and obtain higher profits through monetary recoveries to the Solidarity and Guarantee Fund for activities already included in the plans and paid for by the UPC.

In addition, resource diversion has been proven, which has occurred with the purpose of capitalizing the EPSes with investments in sports teams, purchase of useless health assets, recreational housing, investments in other countries, cooptation of insurance companies and service providers by illegal groups, falsification of official documents with the aim of misappropriating public money, contracting professional consultants who subsequently held high Government posts, and disregarding debts contracted with health institutions, with the approval of the incumbent Government [11,19,36].

The aforementioned factors increased spending within the new health system, representing 7% of the gross domestic product, due to the separation of market-Government rationales within the dominant economic structure and the weakness of the latter. Attempts to solve these problems have increased frustrations in large sectors of the population, precisely in those who are most ill due to inferior living conditions [2,37].

There were no major changes in the system, despite the adjustments made to the SGSSS by Law 1122 of 2007 [38] to improve financing, the provision of health services, and to strengthen public health programs and other areas. The same occurred with Law 1438 of 2011 [10], the purpose of which was:

> […] to strengthen the General System of Social Security in Health through a public health service delivery model that, within the framework of the Primary Health Care strategy, allows for coordinated action by the Government, institutions, and society to improve health and create a healthy environment that provides inclusive, equitable, and higher quality services, where the focus and objective of all efforts are the country's residents.

This very promising law, which captivated many of the country's social workers, only remained on paper, because the structure of the SGSSS did not allow for such transformations. Later, Statutory Law on Health 1751 of 2015 [39] was issued, with the purpose of guaranteeing and regulating the fundamental right to health and establishing its protection mechanisms. This caused euphoria, as it was no longer about the transformation of the system, but the recognition and guarantee of the right to health, despite the narrow understanding of the meaning and scope of this right. Seven years have passed since its promulgation and no significant changes have been made. Furthermore, the ordinary law mentioned in the Statutory Law was never issued, which was intended to create a new health system responding to the principles of the fundamental right to health. There have only been a few resolutions from the Ministry of Health, which seem to only be adjustments to the SGSSS, but do not visualize the new health system.

Many more general and specific problems of the current SGSSS that are detrimental to human dignity could be mentioned. However, here I have presented those that have been investigated and analyzed by different actors in society and of which there is most of the knowledge. Considering all of the above, the new health system for Colombia needs to be reconsidered with human rights at its core.

Declarations on the fundamental right to health and their implications

The WHO, in its Constitution of 1946, declared that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" [40]. The Universal Declaration of Human Rights was proclaimed by the

United Nations General Assembly in Paris in 1948 [41]. Thereafter, other treaties were signed that obliged governments to guarantee them, including the international covenants on civil, political, economic, social, and cultural rights [42], constituting the International Human Rights Framework.

The declarations and efforts of these organizations clearly show that health is a right that is regulated within international legal instruments, which stipulate that it is universal, binding, and indispensable for the exercise of all other human rights.

In addition, the Committee on Economic, Social and Cultural Rights, which monitors these rights, states that the determinants of health are safe drinking water, adequate sanitation and working conditions, safe food, adequate nutrition, adequate housing, a healthy environment, and health-related education and information [43].

It has been a long time since health was declared a fundamental right in the world. However, in Colombia, the Constitutional Court issued different decisions on the matter only in the first decade of the 21st century:

- T-860 (2003), which states that the provision of health services is binding for the responsible entities [44].
- T-016 (2007), which protects the fundamental right to health in four important aspects: availability, accessibility, acceptability, and quality [45].
- T-760 (2008), which declares the right to health to be an autonomous right [46].
- T-121 (2015), which ratifies the fundamental right to health and declares it a governmentally supervised public service, recognized by the statutory legislator as a fundamental and inalienable right [47].
- T-261 (2017), which establishes a cancer patient's right to health to hold special constitutional protection [48].
- T-012 (2020), which ratifies the fundamental right to health and special protection regarding catastrophic or ruinous diseases [49].

However, the country still enforces the SGSSS created by Law 100 [1] and modified by Laws 1122 of 2007 [38] and 1438 of 2011 [10], constituting a scenario contrary to the provisions of the Constitutional Court, with a market system that deepens inequalities.

In 2015, the Government issued Statutory Law 1751 [39], which recognizes the fundamental right to health, but with a restricted meaning. This law departs the Government from the guidelines of international organizations and the needs of the Colombian people, reducing it to only the access to medical services, which is only one component of health care. It ignores the breadth of "a true fundamental right, which is universal, inalienable, inherent to the human person, as well as comprehensive and integrating, essential for the materialization of a decent and quality life, and vital to the real effectiveness of the principle of social equality" [50].

The desire to have a transparent, inclusive, and equitable system that addresses social determinants, changes the biomedical model, and transcends disease in order to impact the living conditions of the Colombian population [51] has not yet been materialized. According to the 1st International Conference on Health Promotion in 1986, the fundamental conditions for health are peace, education, shelter, food, income, a stable ecosystem, social justice, and equity [52]. These are all profound aspects related to human rights that the Government must guarantee, addressing inequalities in the provision of medical services, as well as unjust and avoidable inequities rooted in social, economic, and regulatory structures [53].

Despite the accumulation of knowledge, international covenants, policies, laws, and the legitimate aspirations of the Colombian people, the Ministry and insurance companies have decided to continue this market-based SGSSS, which prevents ending the current mercantilist, individualistic, fragmented, segmented, corrupt, discriminatory, and indolent model, indifferent to the suffering of the population, especially those who are most poor. Instead, if the Government had the political will and social commitment, the Statutory Law on Health would lead to the creation of a new comprehensive health system, shielded from the corrupt, middlemen, and politicians who exploit resources for purposes other than those for which they were allocated [54].

More than two decades ago, the WHO and PAHO proposed acting on the *social determinants of health*, defining them as the circumstances in which people are born, grow, live, work, and age. These circumstances are the result of the distribution of money, power, and resources at the global, national, and local levels, which in turn depends on Government policies [55]. However, this approach is not new. Since the 19th century, the relationship between the living conditions of the population and their state of health has been observed, which revealed that diseases are associated with the economic, environmental, and nutritional limitations of the poor [56].

The WHO expresses it as follows: "The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by an unequal distribution of power, income, goods and services, globally and nationally, and the consequent unfairness in the immediate, visible circumstances of people's lives [...]" [57, p. 336].

From the standpoint of this fundamental right, its effective enjoyment is not viable if the conditions that allow for better opportunities to enjoy wellbeing and good health are nonexistent. Generating these conditions is primarily the obligation of the Government, which must ensure the availability of resources to guarantee this right,

including the private sector, which has responsibilities in the production of social determinants [58].

Contribution to the formulation of a new health system

Based on the above considerations, the overall health system setting will have to be equipped with elements that will lead to the understanding of all Colombians toward a broader health system and a more comprehensive approach to health. No progress can be made in the construction of the system if it is not based on the dignity of life as a whole. Therefore, those responsible for guaranteeing this fundamental right to health will have the moral obligation to apply the constitutional and legal principles derived from respect for life in all its forms. This must be achieved by considering the right of all people to live in a just and equitable society and in a healthy environment that ensures coexistence and leads society to consciously discover the values that dignify life in its social and natural environment.

As mentioned previously, the SGSSS model based on Law 100 has reached the end of its useful life, with major failures and the deterioration of public health. It is, therefore, essential to create a new system, focused on obtaining health outcomes that have an impact on the population, guarantee the right to health [59], change the current paradigm, and take up the words of Hiroshi Nakajima, former director of the WHO, who states that "health is the product of social action and not a mere result of medical care" [60]. This new system must allow transcending from illness to wellness as a comprehensive phenomenon, under the responsibility of the Government and society, and as a consequence of the recognition, protection, respect, and fulfillment of human rights. This implies targeting health and development policies, projects, programs, and resources to achieve greater satisfaction of the population's needs [61].

Within this context, in order to contribute to the creation of a new health system that is structurally different from the current one, the Government and society as a whole must commit themselves to the health of the population. This is to be achieved by advocating for the construction of a system based on the constitutional and legal principles of the fundamental right to health, including different regions and the dispersed and border areas—the real Colombia.

From my point of view, a few elements to be considered in the debate on the future health system should be the materialization of the right to health, the undertaking of the challenges raised in health promotion conferences, health governance, social participation, and intersectorality.

Materializing the right to health. Given that it is a fundamental, autonomous right, and also a government-run public service, the Government takes on the position of the guarantor. As such, failure to comply brings consequences and sanctions, and in order to materialize the right to health, the Government must use legal frameworks, political mechanisms, economic resources, and societal intervention, as mentioned in Law 1751 [39].

Addressing the social determinants is imperative to eliminate unjust and avoidable inequities that negatively influence health and quality of life. Such inequities are the result of low government investment in decent housing, poor coverage for quality education, the high cost of food and its contamination, the informal work of the poor and the minimal income of most formal workers, the high cost of medical services, the low coverage of health services, the lack of drinking water, and a deteriorated environment for most Colombians [62,63].

While the above are problems that concern different sectors within the Government, the needs of the population are not divided in the same way. Hence the urgency to advance in clear and precise mechanisms, establishing achievable, measurable, and assessable agreements between sectors. These must be characterized by comprehensive actions for improving the quality of life and, therefore, the health of the population. National, departmental, and municipal authorities must be present in this intervention, guaranteeing wellbeing and consolidating comprehensive public health and development policies.

It is the obligation of the Government at its different levels, as well as of the private sector and society in general, to address the complex problems of health and wellbeing. In view of this, it is necessary to transcend the boundaries of the health sector, making fundamental agreements, embodied in health-oriented and integrative public policies between the Government, sectors, companies, and institutions. These should go beyond conceptualizations, speeches, commitments, and unfulfilled goals, and should guarantee the materialization of the right to health through joint work in an integrated, conscious, and interactive relationship [64], which includes social participation and intersectorality as key elements in the transformation of the health system.

The new health system must be based on *human dignity* as the maximum expression of the fulfillment of human rights, with principles of equity, universality, comprehensiveness, and respect for differences. In addition, it should be financed by taxes and be complemented by employee and employer contributions, constituting a sole fund for covering health needs. Intermediation and segmentation of the population based on ability to pay and types of enrollment should be totally eliminated, with full knowledge of the population's quality of life conditions.

Undertaking the challenges raised in health promotion conferences. In the new health system, it is inexcusable not to return to the approaches developed in the health promotion conferences, from the Ottawa

Charter (1986) [26] to the Helsinki Declaration (2013) [65]. These have given rise to a field of action based on the development of healthy public policies, the creation of health-promoting environments, the development of personal skills, the reorientation of health services, the strengthening of community action, and intersectorality.

The Ottawa Charter [26] states that there is a need to *reorient health services*. Therefore, the new health system should strengthen the levels of care, formalize the health services network, and establish care models according to the health conditions of the population and their geographic characteristics. This must be achieved without giving the excuse that the dispersed population does not have access to health care because of their geographical conditions. Levels of care should be strengthened mainly in the less developed municipalities, so as not to congest the centers, and must define the appropriate network for referral and counter-referral processes. The supply of high-complexity services must be rationalized so that they respond to the needs of the population and not to the profits of the private sector.

Health governance. The new health system must be based on health governance, typified by social participation and the coordination of national and local actors, and by clear and precise decision making, weighing the consequences for the present and the future of the health of the population. In addition, it should implement public policies through negotiation, not imposition, and through a committed and active leadership to guarantee the right to health, with effects such as transparency, participation, performance and accountability reporting, integrity, and political capacity to guide health care in the country [64, 66].

The importance of the aforementioned aspects lies in the fact that transparency in decision-making and in their results will legitimize public decisions and contribute to the trust of the citizens.

Social participation will allow the population to express their needs, share knowledge about different issues, and become actively involved.

In turn, the decisions that are made as well as their results can be informed and explained to the different actors through performance and accountability reporting.

On the other hand, integrity refers to the ethical dimensions related to decision-making and respect for regulations, seeking beneficence and non-harm, the open fight against corruption, and that health authorities at all levels of the Government and its institutions take a clear and transparent position on health.

Lastly, political capacity, embodied in the health authority and the Government, is necessary for transforming problems into well-defined, viable, and coherently designed policies, consistent with the objectives and resources of the health system [65].

Social participation. This is a cornerstone of the health system within the framework of the Political Constitution, the Participation Policy (issued by Resolution 2063 of 2017 [67]), and the Statutory Law on Health (Law 1751 of 2015 [39]), which aim to allow citizens, families, and communities to influence public decisions that concern them, in order to legitimize public policies and comprehensive projects aimed at the population.

To achieve this, the fractures and problems that hinder effective social intervention in public management must be overcome, taking advantage of the capacity of social actors in national, regional, and local scenarios [58,68,69].

Intersectorality. This term has been defined as the "coordinated intervention of institutions representing more than one social sector, in actions aimed, totally or partially, at dealing with problems related to health, well-being, and quality of life" [70, p. 1]. Health governance is not possible without social participation and intersectorality. Recognizing and implementing ethical-political and operational guidelines for all actors and instances is of great significance so that social participation in health is effective and long-lasting [68,69].

Governance reclaims the power of intersectorality as a mechanism for decision-making, coordination, commitment, and collaboration, which has had little development due to the contradictions, restrictions, resistance, and self-interest of sectors that prefer to give partial answers to complex problems. Intersectorality holds immense value for analyzing complex issues and generating comprehensive solutions, thus becoming a political and technical tool [68,69] that, through partnerships and commitments, promotes the integration of public health policies into all public development policies.

Conclusions

The SGSSS crisis is observable and verifiable through numerous studies and scientific articles. This has revealed the failures of the system and the frustrations of the population in general and, in particular, of the most vulnerable, in the face of the Government's indolence by letting time pass without taking ownership of the country's health issues.

The fundamental right to health has been repeatedly violated by all types of SGSSS actors at the national, departmental, and local levels. It is essential to materialize the fundamental right to health, even if the time period for this is diffuse. To this end, there are constitutional and legal instruments that make it possible to advance towards the effective enjoyment of this right.

The new health system must be based on human dignity as the highest expression of the fulfillment of human rights. To achieve this, it is essential that the Go-

vernment and society commit themselves to the materialization of the fundamental right to health, with a new health system based on constitutional and legal principles. These must include social participation, intersectorality, health promotion, and financing through taxes and employee-employer contributions, without intermediation and with a strengthened health authority present at the different levels within the Government.

Other aspects to be considered for the new health system would be to reach clear and precise fundamental agreements on public policies in health and development with all sectors of the central Government. These agreements must favor the entire population, thereby optimizing resources and materializing the fundamental right to health. Likewise, sustainable and fair recruitment of human talent in health should be guaranteed, and the commitments of international health organizations must be fulfilled, including the results of the health promotion conferences. Finally, it is necessary to develop ethical, systematic, planned, and proactive health practices, with comprehensive and integrating approaches in each territory.

Declarations of funding

There was no source of funding.

Declaration of competing interest

I have no conflicts of interest.

Declaration of responsibility

I take responsibility for what is written in this essay.

References

1. Colombia, Congreso de la República. Ley 100, por la cual se crea el Sistema General de Seguridad Integral y se dicta otras disposiciones (1993 dic. 23).
2. Hernández M. El derecho a la salud en colombia: obstáculos estructurales para su realización. Rev. Salud Pública [internet]. 2000 [citado 2022 jul. 10]; 2(2):121-44. Disponible en: https://revistas.unal.edu.co/index.php/revsaludpublica/article/view/18882/19840
3. Banco Mundial. El financiamiento de los servicios de salud en los países en desarrollo. Una agenda para la reforma [internet]; 1987 [citado 2022 jul. 10]. Disponible en: https://iris.paho.org/handle/10665.2/17647
4. Restrepo J, Casas-Bustamante L, Espinal J. Cobertura universal y acceso efectivo a los servicios de salud: ¿qué ha pasado en Colombia después de diez años de la Sentencia T-760? Rev. Salud Pública. 2018;20(6):670-6. DOI: https://doi.org/10.15446/rsap.V20n6.78585
5. Agudelo C, Botero J, et al. Sistema de salud colombiano: 20 años de logros y problemas. Ciênc. Saúde Coletiva. 2011;16(6). DOI: https://doi.org/10.1590/S1413-81232011000600020
6. Gaviria A. Discurso del Ministro de Salud. Diez razones de optimismo sobre el sistema de salud en Colombia. 24o Foro Farmacéutico de la ANDI. Boletín de Prensa 085 [internet]; 2017 [citado 2022 jun. 21]. Disponible en: https://www.minsalud.gov.co/Paginas/Diez-razones-de-optimismo-sobre-el-sistema-de-salud-en-Colombia.aspx
7. Colombia. Ministerio de Salud. ABC de la unificación de los planes de salud. Boletín de Prensa 186 [internet]; 2012 [citado 2022 jul. 1]. Disponible en: https://minsalud.gov.co/Paginas/ABC%20de%20la%20Unificaci%C3%B3n%20del%20POS.aspx
8. Colombia, Ministerio de Salud y Protección Social. Resolución 0002292, por la cual se actualizan y establecen los servicios y tecnologías de salud financiados con recursos de la Unidad de Pago por Capitación (UPC) (2021 dic. 23).
9. Colombia. Ministerio de Salud. Colombia llegó al aseguramiento universal en salud al alcanzar el 99,6 %. Boletín de Prensa 373 [internet]; 2022 [citado 2022 jun. 30]. Disponible en: https://www.minsalud.gov.co/Paginas/Colombia-llego-al-aseguramiento-universal-en-salud-al-alcanzar-el-99.6.aspx
10. Colombia, Congreso de la República. Ley 1438, por medio de la cual se reforma el Sistema General de Seguridad Social en Salud y se dictan otras disposiciones (2011 ene. 19).
11. Hernández M. Reforma sanitaria, equidad y derecho a la salud en Colombia. Cad. Saúde Pública [internet]. 2002 [citado 2021 nov. 5]; 18(4):991-1001. Disponible en: https://www.scielosp.org/pdf/csp/2002.v18n4/991-1001/es
12. Hernández J, Rodríguez D, Corrales J. Barreras de acceso administrativo a los servicios de salud en población colombiana. Ciênc. Saúde Coletiva. 2015;20(6):1947-58. DOI: https://doi.org/10.1590/1413-81232015206.12122014
13. Marín Y, Chávez B. Inconsistencias en la afiliación al sistema de salud colombiano: barrera administrativa para la atención integral de las urgencias médicas. Rev Fac. Nac. Salud Pública [internet]. 2014 [citado 2021 oct. 9]; 32(1):62-70. Disponible en https://revistas.udea.edu.co/index.php/fnsp/article/view/13241
14. Vargas J, Molina G. Acceso a los servicios de salud en seis ciudades de Colombia: limitaciones y consecuencias. Rev Fac. Nac. Salud Pública [internet]. 2009 [citado 2021 nov. 21]; 27(2):121-30. Disponible en: https://revistas.udea.edu.co/index.php/fnsp/article/view/259
15. Tovar L, Arrivillaga M. Estado del arte de la investigación en acceso a los servicios de salud en Colombia, 2000-2013: revisión sistemática crítica. Rev. Gerenc. Polit. Salud. 2014;13(27):12-26. DOI: https://doi.org/10.11144/Javeriana.rgyps13-27.eaia
16. Echeverri E. La salud en Colombia: abriendo el siglo… y la brecha de las inequidades. Rev. Gerenc. Polit. Salud [internet]. 2002 [citado 2021 nov. 22]; 1(3):76-94. Disponible en: https://www.redalyc.org/pdf/545/54510306.pdf
17. Rodríguez C, Molina G, Jiménez S. Características de las tutelas en salud tramitadas en Medellín, Colombia. Invest. Educ. Enferm [internet]. 2010 [citado 2021 dic. 7]; 28(1): 92-100. Disponible en: https://www.redalyc.org/articulo.oa?id=105215294012
18. Molina G, Vargas J, Muñoz I, et al. Dilemas en las decisiones en la atención en salud. Ética, derechos y deberes constitucionales frente a la rentabilidad financiera en el sistema de salud colombiano. Rev. Gerenc. Polit. Salud [internet]. 2010 [citado 2021 oct. 9]; 9(18):103-17. Disponible en: https://www.redalyc.org/articulo.oa?id=54519734010

19. Contreras N. Fundamentos de un nuevo sistema de salud. Revista Sur [internet]. 2018 [citado 2021 oct. 25]. Disponible en: https://www.sur.org.co/fundamentos-de-un-nuevo-sistema-de-salud/
20. Robledo J. Derogar la Ley 100 para sacar a las EPS, que parasitan con la salud de los colombianos. Intervención del senador en el debate de la salud, plenaria del Senado [internet]. 3 de mayo de 2011 [Video]. [citado 2021 oct. 25]. Disponible en: http https://www.youtube.com/watch?v=7015yDEVrfE
21. Rodríguez J. Algunas causas de la crisis financiera en el sistema de salud en Colombia en el 2009. Bogotá: Universidad Nacional de Colombia, Centro de Investigaciones para el Desarrollo, Econógrafos [internet]; 2012 [citado 2021 oct. 25]. Disponible en: http://fce.unal.edu.co/media/files/CentroEditorial/documentos/econografos/EE/econografos-EE-30.pdf
22. Gañan J. Los muertos de la Ley 100: prevalencia de la libertad económica sobre el derecho fundamental a la salud, una razón de su ineficiencia caso del Plan Obligatorio de Salud del régimen contributivo (POSC) [tesis doctoral]. [Bogotá]: Universidad Externado de Colombia [internet]; 2010 [citado 2022 ago. 27]. Disponible en: https://bdigital.uexternado.edu.co/entities/publication/7326ab5a-b2ee-405a-bc6a-e1b9abd9c7c0
23. Rodríguez D. Enfermedad crónica avanzada, padecimiento psíquico y Sistema General de Seguridad Social en Salud (SGSSS). Revista de Psicología Universidad de Antioquia [internet]. 2013 [citado 2021 oct. 9]; 5(1):75-92. Disponible en: https://revistas.udea.edu.co/index.php/psicologia/article/view/18049
24. Fontalvo D, Gómez D, Gómez. Análisis de la política para el control de la tuberculosis en Colombia. Rev Peru Med Exp Salud Pública [internet]. 2014 [citado 2021 sep. 22]; 31(4):775-80. Disponible en: http://www.scielo.org.pe/scielo.php?pid=S1726-46342014000400025&script=sci_abstract&tlng=en
25. Ahumada C. La penuria de la salud pública. Rev. Gerenc. Polit. Salud [internet]. 2000 [citado 2021 sep. 22]; 1(3):47-56. Disponible en: https://revistas.javeriana.edu.co/index.php/gerepolsal/article/view/2882
26. Carta Ottawa de 1986. Salud Pública Educ Salud [internet]. 2001 [citado 2022 ene. 25]; 1(1):19-22. Disponible en: https://www.paho.org/hq/dmdocuments/2013/Carta-de-ottawa-para-la-apromocion-de-la-salud-1986-SP.pdf
27. Colombia, Ministerio de Salud. Informe anual del Consejo Nacional de Seguridad Social en Salud a las Comisiones Séptimas de Senado de la República y Cámara de Representantes, 1998-1999. Santafé de Bogotá (1999 jul.).
28. Franco S. Para que la salud sea pública: algunas lecciones de la reforma de salud y seguridad social en colombia. Revista Gerencia y Políticas de Salud [internet]. 2003 [citado 2022 oct. 21]; 2(4): 58-69. Disponible en: https://www.redalyc.org/pdf/545/54520406.pdf
29. Bogotá, Secretaría Distrital de Salud. Informe final de asesoría a la Secretaría Distrital de Salud de Santafé de Bogotá;1998.
30. Eslava J. Hospital universitario y crisis hospitalaria en Colombia. Rev. Gerenc. Polit. Salud [internet]. 2002 [citado 2021 oct. 7]; 1(2):41-44 Disponible en: https://revistas.javeriana.edu.co/index.php/gerepolsal/article/view/2900
31. Gorbaneff Y, Torres S, Contreras N. Fuentes de poder de las aseguradoras frente a las prestadoras hospitalarias en el sistema de salud colombiano. El caso de la concentración industrial. Rev. Gerenc. Polit. Salud [internet]. 2008 [citado 2022 ene. 9]; 7(14):177-86. Disponible en https://revistas.javeriana.edu.co/index.php/gerepolsal/article/view/2686
32. García C. El hospital como empresa: nuevas prácticas, nuevos trabajadores. Universitas Psychologica [internet]. 2007 [citado nov. 8 de 2021]; 6(1):143-54. Disponible en: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1657-92672007000100014
33. Patiño J. El hospital, una institución social única. Rev Colomb Cir [internet]. 2006 [citado 2022 ene. 23]; 21(4):204-7. Disponible en: https://www.revistacirugia.org/index.php/cirugia/article/view/1162
34. Villar L. La Ley 100: el fracaso estatal en la salud pública. Escuela de Medicina Universidad Industrial de Santander [internet]; 2006 [citado 2021 nov. 9]. Disponible en: https://cedetrabajo.org/wp-content/uploads/2012/08/36-14.pdf
35. Patiño J. El sistema de salud de Colombia: crisis sin precedentes. Rev Colomb Cir [internet]. 2013 [citado 2021 nov. 5]; 28(4):259-61. Disponible en: https://www.revistacirugia.org/index.php/cirugia/article/view/346
36. Peñaloza R. Economía política de la emergencia social: las negociaciones políticas de los decretos. Rev. Gerenc. Polit. Salud [internet]. 2010 [citado 2021 nov. 5]; 9(18, Suppl.):61-69. Disponible en: https://revistas.javeriana.edu.co/index.php/gerepolsal/article/view/2647
37. Mossos Jiménez MA, Mora Lemu G. Movimientos sociales subalternos: análisis crítico del discurso del Movimiento Nacional por la Salud y la Seguridad Social en Bogotá. Controversia [internet]; (204):47-75. [Consultado 2022 oct. 21]. Disponible en: https://revistacontroversia.com/index.php/controversia/article/view/184
38. Colombia, Congreso de la República. Ley 1122, por la cual se hacen algunas modificaciones en el Sistema General de Seguridad Social en Salud y se dictan otras disposiciones (2007 ene. 9).
39. Colombia, Congreso de la República. Ley Estatutaria 1751 del 16 de febrero de 2015, por medio de la cual se regula el derecho fundamental a la salud y se dictan otras disposiciones (2015 feb. 16).
40. Organización Mundial de la Salud (OMS). Constitución de la OMS: principios. La OMS mantiene su firme compromiso con los principios establecidos en el preámbulo de la Constitución [internet]; s. f. [citado 2021 ago. 30]. Disponible en: https://www.who.int/es/about/governance/constitution
41. Naciones Unidas. Declaracion Universal de los Derechos Humanos [internet]; 1948 [citada 2022 oct. 21] Disponible en: https://www.un.org/es/about-us/universal-declaration-of-human-rights
42. Pacto Internacional de Derechos Civiles y Políticos. Adoptado (PIDESC) y abierto a la firma, ratificación y adhesión por la Asamblea General en su resolución 2200 A (XXI), Artículo 12 [internet]; 16 de diciembre de 1966 [citado 2021 may. 21]. Disponible en: https://www.refworld.org.es/docid/5c92b8584.html
43. Organización Mundial de la Salud (OMS). Estándares Internacionales sobre el Derecho a la Salud en el Sistema de Naciones Unidas [internet]; 2015. [citado 2022 feb. 9]. Disponible en: http://pensamiento.unal.edu.co/fileadmin/recursos/focos/focosalud/docs/estandares_internacionales_sobre_derecho_a_la_salud_en_la_onu.pdf
44. Colombia, Corte Constitucional. T-860. Sala Séptima de Revisión de la Corte Constitucional. M. P. Eduardo Montealegre [internet]; 2003 [citado 2021 sep. 2]. Disponible en: https://www.corteconstitucional.gov.co/relatoria/2003/t-860-03.htm
45. Colombia, Corte Constitucional. T-016. Sala Séptima de Revisión de la Corte Constitucional. M. P. Humberto Antonio Sierra [internet]; 2007 [citado 2022 abr. 4]. Disponible en: https://www.corteconstitucional.gov.co/relatoria/2007/T-016-07.htm
46. Colombia, Corte Constitucional. T-760. Sala Segunda de Revisión de la Corte Constitucional. M. P. Manuel José Cepeda [internet];

2008 [citado 2021 may. 15]. Disponible en: https://www.corteconstitucional.gov.co/relatoria/2008/t-760-08.htm

47. Colombia, Corte Constitucional. T-121. Sala Tercera de Revisión de la Corte Constitucional. M. P. Luis Guillermo Guerrero [internet]; 2015 [citado 2021 jun. 15]. Disponible en: https://www.corteconstitucional.gov.co/RELATORIA/2015/T-121-15.htm
48. Colombia, Corte Constitucional. T-261/17. Sala Octava de Revisión de la Corte Constitucional. M. P. Alberto Rojas Ríos [internet]; 2017 [citado 2022 jul. 8]. Disponible en: https://www.corteconstitucional.gov.co/relatoria/2017/T-261-17.htm
49. Colombia, Corte Constitucional. T-012/20, Sala Segunda de Revisión de la Corte Constitucional. M. P. Diana Fajardo Rivera [internet]; 2017 [citado 2022 jul. 8]. Disponible en: https://www.corteconstitucional.gov.co/relatoria/2020/T-012-20.htm
50 Gañán J. De la naturaleza jurídica del derecho a la salud en Colombia. Monitor Estratégico [internet]. 2013 [citado 2021 abr. 4]; (3):7-19. Disponible en: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/IA/SSA/naturaleza-juridica-derecho-salud-colombia.pdf
51 Torres M. Reseña. Acción de tutela en salud: piedra en el zapato en la consolidación de las reformas de mercado. Rev. Gerenc. Polit. Salud [internet]. 2014 [citado 2021 abr. 4]; 13(27):363-9. Disponible en: https://repository.javeriana.edu.co/handle/10554/25304
52. De Currea Lugo V, Hernández M, Paredes N. La salud está grave. Una visión desde los derechos humanos. Bogotá: Plataforma Colombiana de Derechos, Democracia y Desarrollo [internet]; 2000 [citado 2022 feb. 6]. Disponible en: https://www.worldcat.org/es/title/salud-esta-grave-una-vision-desde-los-derechos-humanos/oclc/45772648
53. Guerra D, Cardona A, Gómez B, et al. Experiencias y lecciones de un Observatorio de Salud en Colombia. Medellín: Personería de Medellín, Universidad de Antioquia; La Carreta Editores [internet]; 2011 [citado 2022 sep. 27]. Disponible en: https://www.udea.edu.co/wps/wcm/connect/udea/d4c58f79-6c90-4ca0-8b03-dcd0f2608a84/Experiencia%2BObservatorio.pdf?MOD=AJPERES
54. Organización Mundial de la Salud (OMS). Subsanar las desigualdades en una generación. Alcanzar la equidad sanitaria actuando sobre los determinantes sociales de la salud. Informe final de la Comisión sobre Determinantes Sociales de la Salud [internet]; 2008 [citado 2022 ene. 18]. Disponible en: https://apps.who.int/iris/handle/10665/44084
55. Álvarez L. Los determinantes sociales de la salud: más allá de los factores de riesgo. Rev. Gerenc. Polit. Salud [internet]. 2009 [citado 2022 feb. 18]; 8(17):69-79 Disponible en:]https://revistas.javeriana.edu.co/index.php/gerepolsal/article/view/2657
56. López O, Escudero J, Carmona L. Los determinantes sociales de la salud. Una perspectiva desde el Taller Latinoamericano de Determinantes Sociales de la Salud, ALAMES. Medicina Social [internet]. 2008 [citado 2022 ene. 22]; 3(4):323-335. Disponible en: https://www.medicinasocial.info/index.php/medicinasocial/article/view/260
57. Organización Mundial de la Salud (OMS). Declaración de Adelaida. Segunda Conferencia Mundial de Promoción de la Salud; 1988.
58. Cunill Grau N. La intersectorialidad en el gobierno y gestión de la política social. Ponencia X Congreso Internacional del CLAD sobre la reforma del Estado y de la administración pública, Santiago, Chile [internet]. 18-21 oct. 2005 [citado 2021 sep. 28]. Disponible en: https://issuu.com/wendyrb30/docs/la_intersectorialidad_en_el_gobiern
59. Matamoros M, Holguín W. Implementación de servicios públicos para la ciudadanía: la importancia de la intersectorialidad en el territorio para generar micro-planificación. Ponencia XIX Congreso Internacional del CLAD sobre la reforma del Estado y de la administración pública, Quito, Ecuador. 11-14 nov. 2014.
60. Castell P. La intersectorialidad y sistemas de salud. La experiencia cubana. La Habana: ENSAP; 2003.
61. Castell P. Comprensión conceptual y factores que intervienen en el desarrollo de la intersectorialidad. Rev. Cubana Salud Pública [internet]. 2007 [citado 2021 oct. 4]; 33(2):1-3. Disponible en: http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S0864-34662007000200009
62. Organización Mundial de la Salud (OMS). La función de la OMS en la gobernanza de la acción sanitaria mundial. Informe de la directora general. Consejo Ejecutivo 132.a reunión [internet]; 2013 [citado 2021 ago. 19]. Disponible en: https://apps.who.int/iris/handle/10665/82788
63. Observatorio de Biopolítica. Conferencias mundiales de promoción de la salud. [internet]; 2017 [citado 2021 ago. 19]. Disponible en: https://biopolitica.net/2017/05/10/conferencias-mundiales-de-promocion-de-la-salud/
64. Santoro V. La salud pública como problema de gobierno. Análisis de los problemas sociales de la salud bajo el modelo de gobernanza. [Tesis doctoral], https://tdx.cat/bitstream/handle/10803/325153/vsl1de1.pdf?sequence=1&isAllowed=y [citado 2022 oct. 21] Disponible en: https://tdx.cat/bitstream/handle/10803/325153/vsl1de1.pdf?sequence=1&isAllowed=y
65. Organización Mundial de la Salud (OMS). Conferencia Mundial de Promoción de la Salud, Helsinki, Finlandia. La declaración de Helsinki sobre salud en todas las políticas [internet]. 10 al 14 junio 2013. [citado 2022 sep. 28]. Disponible en: https://www.sanidad.gob.es/profesionales/saludPublica/prevPromocion/docs/DeclaracionHelsinki.pdf
66. Hufty M.Gobernanza en salud pública: hacia un marco analítico. Rev. Salud Pública [internet]. 2010;12(Sup.1)39-61. Disponible en: DOI: https://doi.org/10.1590/S0124-00642010000700004
67. Colombia, Ministerio de Salud y Protección Social. Resolución 2063, por medio de la cual se adopta la política de participación social en salud (2017 jun. 9).
68. Castell P. La intersectorialidad, una tecnología que despega con fuerza. Rev. Cubana Salud Pública [internet]. 2010 [citado 2022 feb. 13]; 36(2):101-2. Disponible en: https://www.redalyc.org/articulo.oa?id=21416135001
69. Cunill-Grau, N. La intersectorialidad en las nuevas políticas sociales. Un acercamiento analítico-conceptual. Rev. Gest. Polít. Pública [internet]. 2014 [citado 2022 feb. 24]; 23(1):5-46. Disponible en https://www.scielo.org.mx/scielo.php?script=sci_arttext&pid=S1405-10792014000100001
70. Organización Panamericana de la Salud, Organización Mundial de la Salud. Documento conceptual: Intersectorialidad. Concurso de experiencias significativas de promoción de la salud en la región de las Américas. [Consultada 0ctubre 21 de 2022] disponible en: https://www.paho.org/hq/dmdocuments/2017/promocion-salud-intersectorialidad-concurso-2017.pdf