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*La Calidad Académica,  
un compromiso institucional*



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## Colombian Health System: integration for quality

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# COLOMBIAN HEALTH SYSTEM: INTEGRATION FOR QUALITY

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SISTEMA DE SALUD COLOMBIANO:  
INTEGRACIÓN PARA LA CALIDAD

○ SISTEMA DE SAÚDE COLOMBIANO:  
INTEGRAÇÃO PARA A QUALIDADE

LE SYSTÈME DE SANTÉ COLOMBIEN:  
INTÉGRATION POUR LA QUALITÉ

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## ABSTRACT

The central objective of this document is to analyze the elements of integration and quality on the Colombian Health System and to verify their articulation in accordance with the postulates set forth by the national government in terms of quality. Based on a qualitative approach, supported by the bibliographic review as a tool for research and deepening, a matrix of documents associated with the research topic of the last five years is made. The results indicate that Colombia's health model has been forged in recent decades and has incorporated elements such as universality, coverage and quality. The analysis of these aspects can facilitate or support research in the health sector at the national or international level.

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**KEYWORDS:**

Colombia, coverage, health, quality.

**JEL CLASSIFICATION:**

I18, I38.

**RESUMEN**

El objetivo central de este documento es analizar los elementos de integración y calidad en el sistema de salud colombiano y verificar su articulación de acuerdo con los postulados establecidos por el gobierno nacional en términos de calidad. Basado en un enfoque cualitativo, respaldado por la revisión bibliográfica como herramienta para la investigación y la profundización, se elabora una matriz de documentos asociados con el tema de investigación de los últimos cinco años. Los resultados indican que el modelo de salud de Colombia se ha forjado en las últimas décadas y ha incorporado elementos como la universalidad, la cobertura y la calidad. El análisis de estos aspectos puede facilitar o apoyar la investigación en el sector de la salud a nivel nacional o internacional.

**Palabras clave:** calidad, cobertura, Colombia, salud.

**Clasificación JEL:** I18, I38.

**RESUMO**

O objetivo central deste documento é analisar os elementos de integração e qualidade do sistema de saúde colombiano e verificar sua articulação de acordo com os postulados estabelecidos pelo governo nacional em termos de qualidade. Com base em uma abordagem qualitativa, apoiada pela revisão bibliográfica como ferramenta para a pesquisa e o aprofundamento, elabora-se uma matriz de documentos associados com o tema de pesquisa dos últimos cinco anos. Os resultados indicam que o modelo de saúde da Colômbia foi forjado nas últimas décadas e incorporou elementos como a universalidade, a cobertura e a qualidade. A análise destes aspectos pode facilitar ou apoiar a investigação no sector da saúde a nível nacional ou internacional.

**Palavras-chave:** qualidade, cobertura, Colômbia, saúde.

**Classificação JEL:** I18, I38.

## RESUME

L'objectif principal de ce document est d'analyser les éléments d'intégration et de qualité du système de santé colombien et d'en vérifier l'articulation conformément aux postulats établis par le gouvernement national en termes de qualité. Sur la base d'une approche qualitative, appuyée par la révision bibliographique en tant qu'outil de recherche et d'approfondissement, une matrice de documents associés au thème de recherche des cinq dernières années est élaborée. Les résultats montrent que le modèle de santé de la Colombie s'est forgé au cours des dernières décennies et a incorporé des éléments tels que l'universalité, la couverture et la qualité. L'analyse de ces aspects peut faciliter ou soutenir la recherche dans le secteur de la santé au niveau national ou international.

**Mots clés:** Colombie, couverture, qualité, santé.

**Classification JEL:** I18, I38.

## INTRODUCTION

In Colombia, health has been configured as a fundamental right, which has made it necessary to carry out programs and strategies that promote social protection; as things stood in 2016, the Ministry of Health and Social Protection unveiled the Integral Model of Health Care (MIAS) (Moreno, 2016), designed as an integral part of the Comprehensive Health Care Policy framework (PAIS). This is directly related to the need to provide the sector with tools to guarantee the provision of quality services that are also in line with the rights envisioned in the national Constitution (Palma *et al.*, 2017).

The MIAS is broadly established as an integration alternative based on the health outcomes of individuals, families and communities, understood as individuals with the right to enjoy timely health and dignified treatment throughout the national territory (Palma *et al.*, 2017); in this regard, it is developing a series of strategies such as primary health care with an emphasis on the family and community, comprehensive risk care and management, and a differential approach, with a view to achieving the articulation and harmonization of insurance, the provision of services, and the development of public health policies and programmes through social management processes and intersectoral policy (Palma, 2017).

In view of the foregoing, once the above-mentioned strategies are integrated, MIAS seeks to guarantee health care with equity, centered on people, with standards of opportunity, continuity, comprehensiveness, acceptability and quality, through processes of prioritization, intervention and institutional arrangements aimed at coordinating actions and interventions (Minsalud, 2012).

For all these reasons, the thesis of the present document is to demonstrate the importance of MIAS as an adjunct in the provision of a service based on equity, quality and universality, through which it is intended to generate better health conditions for the country's inhabitants. Therefore, by identifying the structure and scope of MIAS in Colombia, it is possible to determine how it contributes to the protection of the rights and guarantees stipulated for this purpose.

## 1. THE HEALTH CONTEXT IN COLOMBIA

The Health System in Colombia is an essential part of the Social Security System, which is regulated by the National Government, through the Ministry of Health and Social Protection, having its magisterial order in the upper chart. Initially, based on articles 48 and 49 of the Constitution, health is presented as a public service provided by the State and conceived as an economic, social and cultural right due to its benefits nature (Vélez, 2016); however, despite its importance as a fundamental part of the fundamental right to life, a hierarchical division between first- and second-generation rights was marked from the outset; where the former are of immediate application and direct protection through tutelary action; and the latter are of a programmatic nature and progressive development (Bernal and Barbosa, 2015).

As a complement to the above-mentioned articles and as a differentiating mechanism, Law 100 of 1993 was enacted, which, among others, structured the General Social Security Health System (SGSSS) having as its essential objective the regulation of health as a public service, thus forging conditions for access by the entire population at all levels of care, taking into account the contingencies of general illness and maternity of its members and beneficiaries, and also guaranteeing access to health promotion,

protection and recovery services for all persons (Restrepo and Escobar, 2017).

The regulations issued in 1993 sought to expand the financial protection of families against the calamitous expenses derived from the costs associated with health services, and optimized access through the extension of coverage, which gave a profound transformation to the previous National Health System, moving from a State assistance model and centralized planning to a SGSSS, guided and controlled by the State, based on universal coverage with the exercise of two regimes: the contributory and the subsidized (Franco, 2012).

In spite of this enormous differentiation in the categorization of the service, the same law guaranteed a comprehensive health protection plan for all, with preventive care, medical-surgical care and essential medicines, known as the Mandatory Health Plan (POS), promoting equity, universality and equality in access to health services. Thus, Law 100 of 1993 marked a milestone with respect to the way health services would be provided in the country (Jaramillo-Mejía and Chernichovsky, 2015).

However, with the implementation of the new health scenario, questions and constant debates have arisen, to the extent that is found that coverage has not been necessary to guarantee access to quality health services. For this reason, the population, in its quest to ensure such access, resorted to the use of Guardianship Action mechanisms (a legal tool for priority cases) in cases in which it felt that the individual's health had been violated or threatened, constituting a remedy accepted by the justice system throughout the country (Castro *et al.*, 2019).

For this reason, under certain circumstances, access to the public Health service may have been demanded through this tool (Guardianship Action) if it was evident that its lack of provision could violate fundamental rights, such as life and human dignity; hence it has been established

as a component of dynamization for decision making in cases of sinister or highly complex health (Pinto *et al.*, 2017).

Subsequently, in a Constitutional Court ruling, it was determined that the understanding of the individual and society, based on the postulates of the Social Rule of Law, must revolve around their human dignity and not principally their freedom; that is, freedom is placed at the service of human dignity as the supreme end of the individual and of society. In this context, health acquires a fundamental connotation as an essential right to guarantee a dignified and quality life to people, allowing their full development in society (Pimienta, 2019). The previous vision was established in a new framework that facilitated progress in the conception of health, insofar as it determined that the central element of the new system is universality, coverage and the concept of human dignity, intimately linked to the concept of health as a right.

In recent times the Congress of the Republic enacted Statutory Law 1751 of 2015 (Jiménez *et al.*, 2016), which elevated the character of health as a service to an autonomous fundamental right, which implies that this is the responsibility of the State, which should tend to ensure that it is guaranteed with *high standards of quality and ensure that all the institutions that make it up provide protection and protection*. In its articles 1 and 2, this law defined the nature and content of the right to health and explicitly recognized its double connotation, as can be seen in figure 1.

**Figure 1.** Health System in Colombia according to Law 1751/2015.



Source: own elaboration, 2015.

As observed in the first instance, Law 1751/2015 incorporated the autonomous and inalienable fundamental right, which includes access to health services in a timely, effective and quality manner for the preservation and promotion of health; secondly, as a compulsory essential public service whose efficient, universal and solidary provision is carried out under the non-delegable responsibility of the State (Jiménez *et al.*, 2016). On the other hand, with respect to the schemes established in Act 100 of 1993, the continuity of the contributory and subsidized scheme was established, although the funding will now be fully public.

This requires the adoption of instruments and the adaptation of these agents to the objectives of the policy and the development of processes that implement the policy beyond its own institutional objectives; which seeks to guarantee the effective enjoyment of the right to health, which expands the regulatory scope of the State from the mere regulation of relations between agents and places it in the citizen, based on its right expressed in integral access as a substantial justification for the implementation of a regulated MIAS (Flórez, 2017).

## 2. COMPREHENSIVE HEALTH CARE POLICY (PAIS)

According to Statutory Law 1751 of 2015, the general objective of the PAIS policy is to orient the system towards the generation of the best health conditions of the population, through the regulation of intervention measures for agents towards access to health services in a timely, effective and quality manner, for the preservation, improvement and promotion of health, in order to guarantee the right to health (Minsalud, 2016d).

The comprehensiveness defined in the policy includes equal treatment and opportunities in

access (principle of equity) and a comprehensive approach to health and disease, consolidating the activities of promotion, prevention, diagnosis, treatment, rehabilitation and palliation for all persons (Flórez, 2017). PAIS seeks to harmonize the guiding principles of the system with insurers and health providers, through care, differentiation and primary care in family health (Cuéllar, 2016).

The policy requires the coordinated interaction of the territorial entities in charge of public health management, insurers and service providers. This coordination implies the implementation and monitoring of territorial health plans, territorial development plans in accordance with the Ten-Year Public Health Plan 2012-2021 with the instruments derived from the national development plans corresponding to the current quaternos (Minsalud, 2016d). In view of the above, it is possible to establish that the PAIS policy is made up of:

- a) A strategic framework that transforms principles and objectives into strategies, which established four major strategies for its development: (i) Primary health care (PHC), with a focus on family and community health, (ii) Care, (iii) Comprehensive health risk management, and (iv) Differential approach to territories and populations.
- b) An operational model called MIAS, which adopts the operational and management mechanisms and instruments that guide the intervention of the different agents of the System.

This requires the adoption of instruments and their adaptation to the objectives of the policy, and the development of processes to implement it, beyond its own institutional objectives.

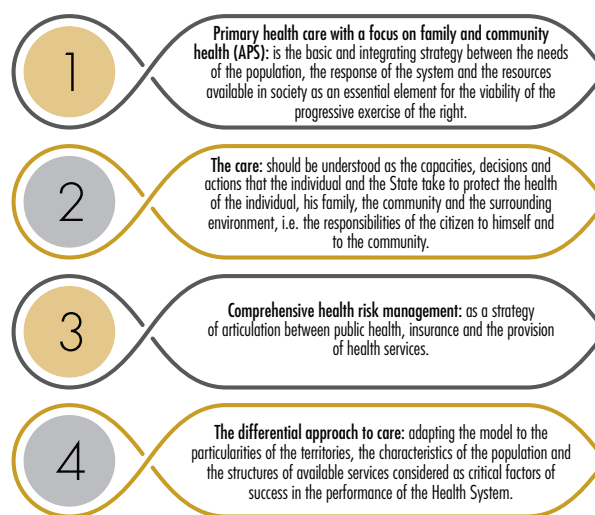
## 2.1 COMPREHENSIVE HEALTH CARE POLICY STRATEGIC FRAMEWORK

The Comprehensive Health Care Policy should contain the strategies and instruments that allow the transformation of the institutional model of Law

100 of 1993 to the objectives of a Health System, centered on the population and its relations at the family and community level. The policy includes the framework of social determinants adopted by the country for the establishment of guidelines in the entire health field (García, 2016).

Therefore, the State recognizes that health problems are generated or enhanced by the environmental, social, cultural, political, economic, educational, habitat and genetic conditions that affect populations in the different territorial spheres that make up the Nation; these social determinants of health consolidate both the protective factors of health conditions and the primary causes of the disease (Minsalud, 2016d). These considerations define four types of strategies for this purpose, shown in figure 2.

Figure 2. PAIS strategies.



Source: own elaboration, 2019.

From the previous figure, it should be emphasized that Primary Health Care (APS) requires a family and community health approach, which serves as an interface between the need to generate new human resource skills and interdisciplinary teams empowered in the development of their capacities to give a social response directed towards the individual, the family and the community (Rodríguez *et al.*, 2016).



In addition, with respect to care, it is necessary to emphasize the importance of citizen participation, since it is not possible to expect results in health if the individual and the community do not adopt behaviors and practices that protect them from health risks (Giovannella *et al.*, 2015).

These strategies allow for the articulation and harmonization of insurance, the provision of health services and the development of public health policies and programmes, in accordance with the health situation of individuals, families and communities; supported by intersectoral social and political management processes, which must be applied to each of the specific population and territorial contexts, as well as having a different approach (Minsalud, 2016d). The instrument that adopts strategies and transforms them into processes is consolidated as a model of comprehensive health care, which will be presented below.

### 3. INTEGRAL MODEL OF HEALTH CARE (MIAS)

The MIAS is an operational model that, based on defined strategies, adopts the tools to guarantee opportunity, continuity, comprehensiveness, acceptability and quality in health care for the population, under conditions of equity and institutional arrangements that direct, in a coordinated manner, the actions of each of the system's agents, under a person-centered vision (Minsalud, 2016b). Thus, the MIAS is the way in which the PAIS policy is implemented, which, based on the strategies defined therein, develops a set of tools (policies, plans, projects, standards, guidelines, protocols, instruments, methodologies, technical documents) for prioritization and intervention processes (Minsalud, 2016c).

#### 3.1 GENERAL SCOPE OF THE MODEL

This model requires the coordinated interaction of territorial entities, insurers, providers and

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other entities that carry out actions on health-related determinants and risks; however, this comprehensiveness does not imply uniqueness, since the characteristics of populations and territories are different (Minsalud, 2016c).

By placing people at the centre, MIAS proposes interventions that include health promotion, care, specific protection, early detection, treatment, rehabilitation and palliation throughout the course of a person's life; this is why it includes actions aimed at generating well-being, as well as those aimed at maintaining health, detecting risks and illness, curing illness and reducing disability (Minsalud, 2016c). To ensure this comprehensiveness, the new units must understand the entire process and must therefore generate intermediate results, final results, health gains or reduction of disability (Cuéllar, 2016).

### 3.2 ESSENTIAL MODEL STRATEGIES

The model includes ten main components or strategies: The starting point is the characterization of the population, according to life course and risk groups; integral health care routes are defined in health promotion and maintenance, risk groups and specific health care events; integral health risk management is proposed, identifying risk groups, designing predictive models, evaluating the effectiveness of services and guaranteeing the interoperability of information systems; a territorial delimitation is proposed that includes the urban, high rurality and dispersed population; integrated networks of health service providers with their primary and complementary components (Moreno, 2016).

The definition of the role of the insurer in financial risk management, interaction with other actors, and management of service delivery networks; the model proposes a redefinition of the incentive scheme to promote comprehensive health care and health outcomes; an information system centered on the citizen, the family, and the community; and the human resource component proposes

training and harmonization for the development of the model and improvement of working conditions; the latter is aimed at strengthening research, innovation, and appropriation of knowledge specifically on issues related to system stewardship, financial sustainability, resource management, information systems, public policies, access to and quality of service, and public health. The main characteristics of each of these strategies are as follows:

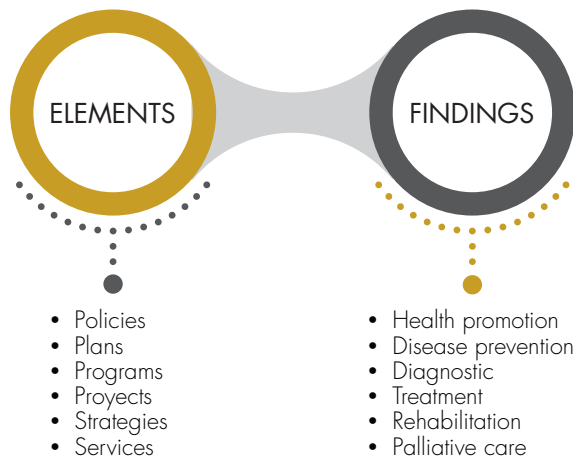
**Characterization of the population:** in order to carry out the implementation of MIAS it is necessary to characterize the populations according to the moments of the course of life and the groups of risk that can affect the health of the people. This activity must be carried out by the system's agents, so that the planning of the services to be provided to the population is related to health needs and problems, and the goals proposed in the Ten-Year Public Health Plan - PDSP 2012-2021 (Minsalud, 2015).

The insurers obtain information for the management of the health risk of the members by declaring the state of health of the persons and characterizing all of their members; in this way they set priorities in the health needs and problems that affect their members, which must be contrasted with the priorities established by the territorial entity in the ASIS.

**Comprehensive Health Care Routes (RIAS):** the RIAS are the set of coordinated, complementary and effective actions to guarantee the right to health, in accordance with figure 3.

According to the next image, it can be established that the RIAS are an instrument that contributes to individuals, families and communities to achieve health results taking into account the particularities of the territory where they live, interact and develop. Therefore, it consists of an obligatory tool that defines to the members of the Health Sector and other sectors, the necessary conditions to assure the integrality in the attention from the actions of care that are

Figure 3. Structure of the RIAS.



Source: Own elaboration, 2019.

expected of the individual, the actions oriented to promote the well-being and the development of the individuals in the environments in which it is developed, as well as the interventions for the prevention, diagnosis, treatment, rehabilitation of the disability and palliation (Minsalud, 2016d).

In this way, the RIAS order intersectoral and sectoral management as a platform for the response that gives rise to health care and interventions aimed at all individuals, families and communities, for which it uses different strategies such as those shown in figure 4.

Figure 4. Types of RIAS strategies.



Source: own elaboration, 2019.

In view of the foregoing, the objective of the RIAS can be interpreted as guaranteeing comprehensive health care for individuals, families and communities through interventions for comprehensive health assessment, early detection, specific protection, diagnosis, treatment, rehabilitation, palliation and health education (Minsalud 2016b):

- Comprehensive care route for the promotion and maintenance of health in the course of individual and collective life, aimed at promoting health, preventing risk, preventing disease and generating a culture of health care in individuals, families and communities; it includes as compulsory care for the entire Colombian population: comprehensive assessment of the state of health, early detection of alterations, specific protection and health education, which includes care for caregivers.
- Comprehensive care routes for risk groups, individual and collective interventions aimed at the timely identification of risk factors and their intervention, either to prevent the emergence of a specific health condition or to make a diagnosis and timely referral for treatment.
- Integral routes of specific attention for events, individual and collective interventions directed mainly to the opportune diagnosis, treatment, rehabilitation and palliation of the events or specific conditions of prioritized health.

**Integral Risk Management in Health (GIRS):** this is a strategy to anticipate events of public health interest, diseases and trauma so that they do not occur, or if they do, to present, detect and treat them early in order to mitigate or shorten their evolution and consequences (Castaño, 2015). This requires the coordinated action of sectorial and extra-sectorial agents in the identification of the circumstances and conditions that influence the appearance and outcome, originating in individuals, groups and the environment where one lives, studies, works or recreates.

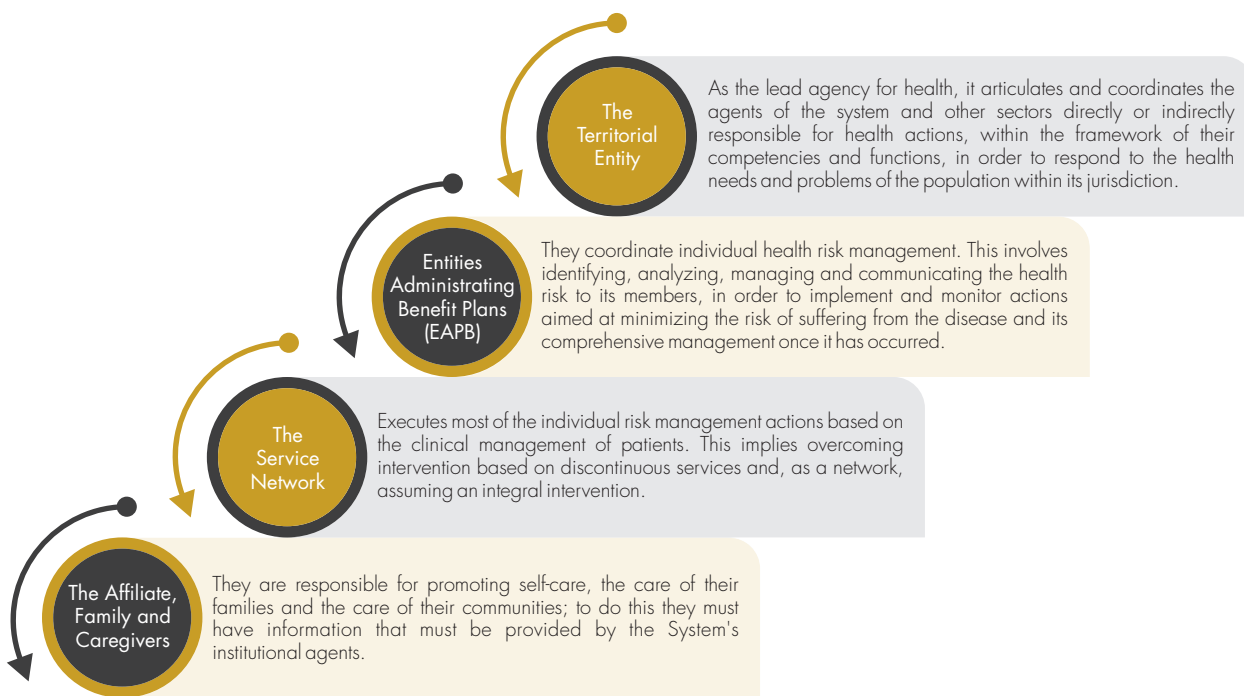
***On the other hand, the network of services includes the development of strategies to support the self-care of members and their families and the implementation of actions for the reduction of risks derived from the clinical management of the disease; and finally, primary providers must manage the integrality of the risk of each individual and family of their assigned population, communicate the health risk and carry out clinical interventions of a preventive, diagnostic and therapeutic nature.***

The classification of people as affected by these circumstances and conditions; and the design and implementation of integral and effective actions to eliminate, reduce or mitigate them (Minsalud, 2016d). In this sense, the objective of this strategy is to achieve a better level of health of the population, a better experience of users during the process of care, and costs commensurate with the results obtained.

In view of the foregoing, it is necessary to bear in mind that in order to achieve compliance, it is necessary to identify and understand the factors that influence the health-disease relationship at an individual and collective level, which is fundamental for adequate risk management, bearing in mind that there is a wide range of health determinants, ranging from biological, individual and community factors, to those related to access to health services, living and working conditions and general socio-economic, cultural and environmental conditions (Castaño, 2015). According to Unisalud (2018), in order to achieve the objectives of Integrated Health Risk Management, the active participation of several agents is required, as illustrated in figure 5.

In relation with this figure, it is possible to establish that the territorial entity executes the collective management of risk, as responsible for the identification, analysis and intervention of collective risks in health; as well as the communication of risk to the population, and the analysis of their perception of it. On the other hand, the Entities Administrating Benefit Plans are in charge of implementing promotional and preventive strategies that can be effectively applied to indivisible population conglomerates seeking to act on some of the proximal and distal determinants of health in order to reduce the probability of the appearance of new morbidity and to control the probability of occurrence of events produced by deficiencies in health services (Minsalud, 2016d).

Figure 5. GRS agents.



Source: own elaboration, 2019.

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**Territorial delimitation:** the execution of the MIAS must be adapted to the different conditions of the territories, since these are understood as the basic unit where the health system and the agents of the General System of Social Security in Health are integrated. This implies a population allocation of health insurance and service delivery, which includes the differential characteristics of demand (social, geographic, ethnic and gender) and existing supply, in terms of the effective availability of services. (Minsalud, 2016d).

**Comprehensive networks of health care providers - RIPSS:** in order to guarantee comprehensive and continuous care for the population, sufficient resources must be available to promote and maintain health, address risks and the different health events of the population, with services organized under the principles of availability, acceptability, accessibility and quality. In this context, the Integrated Networks of Health Service Providers - RIPSS are established, defined as an articulated group of public and private health service providers located in a territorial area. The Integral Model of Health Care proposes that the networks should have a primary provider and a complementary provider in their functional organization (Minsalud, 2016c).

**Role of the insurer:** under the MIAS context, the insurer is obliged to guarantee the technical capacity for health risk management of members and the stability of the delivery network for each territorial area, for which it must form risk groups, adopt and develop comprehensive care routes, manage self-care support, develop capacities to monitor interventions and evaluate

their results and impact on the population, have administrative infrastructure and information management, and interact with other system agents within each territorial area defined for the model, thus achieving Unisalud technical accreditation (2018).

**Incentive system:** the incentive system is a set of incentives aimed at achieving the expected health outcomes; thus, for the implementation of MIAS it is necessary to adjust the scheme of incentives along the chain of provision of health services, so that the products are viable without risking the sustainability of the system and in a complete manner, in order to prevent, palliate or cure the disease by the agents (Minsalud, 2016d). In relation to this, the incentives for the user must be translated into the integral authorization of the activities defined in the RIAS; and for the primary and complementary providers that make up an integral network for the provision of services, it is the guarantee of payment throughout the chain of services provided.

**Information system:** the operation of MIAS requires a person-centered health information system, which implies that information must be collected, analyzed and available, starting at the individual level, and managed in such a way that it allows for the integration of information parameters established by the different agents responsible for providing comprehensive health care; this makes it possible to estimate individual and collective risks, monitor and evaluate interventions and their effects, conduct epidemiological surveillance, and manage health risk (Minsalud, 2016d).

**Human Resource in Health - RHS:** MIAS requires the strengthening of human resources in health, for which actions must be carried out at the level of training, planning and management; for this, actions must be developed at the level of four axes: i) the formation of the RHS; ii) the harmonization of the RHS with the scheme of integral care and provision of services; iii) the strengthening of the RHS responsible for territorial

planning and management in health and iv) management, planning and improvement of working conditions of the RHS at the national and territorial levels; which must be articulated in the territorial health plans to generate real impact on the population (Minsalud, 2016d).

**Research, innovation and knowledge appropriation:** within the framework of research and innovation, in the thematic line of health systems and services at the national and regional levels, it is considered that these should be oriented towards solving the health requirements of the populations, to comprehensively address the environments in which it is developed, and to establish the conditions of the model of care to guarantee the right to health individually (Unisalud, 2018).

**Applicable instruments for implementation:** in order to achieve the implementation of the processes proposed in the MIAS, the national government established three (3) strategies, which must be concomitant and coordinated, as well as applied by all SGSSS agents, within their competencies. These strategies and/or instruments, according to the Minsalud (2016d) are:

- a) *Establishment and strengthening of health system governance:* Understood not only as a power of the sector in charge of the Government, but also as a function of all the members, which implies defining priorities, carrying out monitoring processes, having mechanisms for accountability; for which it is required that the agents of the System, develop a series of practical instruments and structuring of budget to strengthen governance.
- b) *Progressive and gradual implementation:* The gradual development of instruments related to the components of the model that allow for progressive implementation by territorial scope is required; in this regard, the Ministry of Health and Social Protection should structure a centralized institutional team that will serve as an interface between the departmental governors and the directorates

of the Ministry; on the other hand, a technical assistance program will be developed for each department to allow coordinated intervention in the departments.

- c) *Feedback mechanisms and improvement plans*: The model requires dynamic and constant feedback processes to improve its performance and therefore health outcomes. The changes in the model must be solved in an efficient and reliable manner by each of the agents, which means that they will be incorporated according to their pertinence at the moment they are required to guarantee the achievement of the proposed objectives.

## CONCLUSIONS

Once the documentary review proposed for the development of this article has been completed, the following aspects can be generally concluded. Since the reforms carried out in Colombia, health has become a fundamental right, which is indispensable for the satisfaction of the user; thus, every human being has the right to the enjoyment of the highest possible level of quality of health in order to be able to develop in a dignified and appropriate manner. In order to guarantee health quality and coverage, Statutory Law 1751 of 2015 was issued, which regulates the fundamental right to health, based on principles and essential elements that will be responsible for impacting the provision of health services and technologies in order to ensure care in accordance with the needs of the population. By this law, policies were established that define new benefit schemes and new criteria in the provision of services, changes that involve all actors in the system, for which health is understood as an integral and integrating concept.

In view of the foregoing, which have been implemented, among other initiatives, the Comprehensive Health Care Policy (PAIS), which consists of the following: 1. A strategic framework that transforms principles and objectives into strategies, and 2. An operational model called

***However, despite the notorious benefits of MIAS, the active role of the departmental level is required in terms of mobilizing resources and departmental and municipal actors to ensure that the model requires. This support should be translated into the incorporation in development plans and operational plans of actions that put the implementation of the model on the public agenda. Finally, it is ratified that the MIAS aims to guarantee equitable health care, centered on people, with high quality standards, through coordinated and comprehensive health care processes.***

the Integrated Health Care Model (MIAS), based on strategies, adopts the operational and management mechanisms and instruments that guide the intervention of the different agents of the System. Therefore, all actions and interventions related to the promotion and maintenance of health must be prepared to achieve and guarantee complete and timely access to health services, which must be provided with quality, integrity and humanized treatment.

With respect to the benefits of the Integrated Health Care Model (MIAS), there is a guarantee of effective citizen access to health services, with actions and benefits ranging from health promotion, disease prevention, treatment, rehabilitation and social reintegration; In the same way, all agents are articulated, from citizens, territorial governments, EPSs, service providers, providers; and the education sector, which leads to an effective coordination of all sectors oriented to the welfare of the population, to effectively modify the determinants of health, continuously improve health outcomes and close gaps of social inequity.

However, despite the notorious benefits of MIAS, the active role of the departmental level is required in terms of mobilizing resources and departmental and municipal actors to ensure that the model requires. This support should be translated into the incorporation in development plans and operational plans of actions that put the implementation of the model on the public agenda. Finally, it is ratified that the MIAS aims to guarantee equitable health care, centered on people, with high quality standards, through coordinated and comprehensive health care processes.

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