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The Evolution of Health Benefits Packages in Colombia: Thirty Years of Successes and Failures

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ABSTRACT

Health benefits packages in Colombia—what is covered, by whom, and at what cost—have evolved over the past thirty years. Coverage changed from two explicit health benefits packages (with benefits linked to ability to contribute) to an implicit approach that covers, in theory, everything for everyone, excluding a narrow negative list of services and health technologies. This article explores the evolution of priority setting in Colombia during two periods of major reform. Each period had its own advantages and disadvantages associated with different institutional arrangements, processes, and methodologies. Colombia's evolution provides several lessons for other low- and middle-income countries interested in institutionalizing evidence-based priority-setting.

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Health benefits package; implicit rationing; priority setting; universal health coverage

Introduction

In 1993, Colombia embarked on a major health sector reform. The country introduced a mandatory universal social health insurance system known as Sistema General de Seguridad Social en Salud (SGSSS), funded through a combination of payroll contributions and general taxation.¹ The reform introduced competition into insurance and the provision of care through a managed care model. It established a contributory regime for those with the means to pay and a fully subsidized scheme for the poor.¹ At the core of the reform was the introduction of a priority-setting system featuring a health benefits package (HBP) that delineated the list of interventions covered by the system, whom it was for, and at what costs.

Since then, Colombia has made remarkable progress toward universal health coverage, financial risk protection, and equitable access regardless of ability to pay. Coverage increased from 29.2% of the population in 1995 to 99% in 2021 (Figure 1). Out-of-pocket expenditure (OOPE) as a percentage of Current Health Expenditure (CHE) fell from 52% in 1993 to 13.9% in 2021.² OOPE was notably low compared to the Latin America (LatAm) region and is similar to levels observed in other OECD countries (18.4% in OECD countries and 30.1% in the LatAm region in 2021).²

Despite these notable accomplishments, the Colombian health system has faced significant

challenges including financial viability, disparities between urban and rural regions, and an imbalance in the distribution of primary and specialized medical services.¹ In 2021, Colombia spent 28.7 billion USD, or 9.02% of its GDP, on health.² This sum was more than five times the annual health care budget in the early 2000s and was significantly more than what was allocated prior to the health sector reform in 1993. However, despite these significant increases, partly attributable to the COVID-19 pandemic, the health care system's budget has fallen short of meeting increasing demands. In 2032, the annual budget deficit is estimated to reach 0.96% of GDP (approximately 3 billion USD).³

Colombia's budget deficit has been associated with several factors: insurers have failed to handle clinical and financial risks effectively and there has been ineffective and subpar insurance and provider payment systems, but above all, the deficit has been associated with a very generous interpretation of the right to health that is enshrined in the Statutory Law 1751 of 2015.^{4,5} According to this law, every health technology and health service must be covered by the health system, except in particular circumstances.⁵

This article will describe and review the evolution of HBPs in Colombia, from the major health sector reform in 1993 to date, through an examination of major legislation, statutes, and notable judicial rulings, to offer

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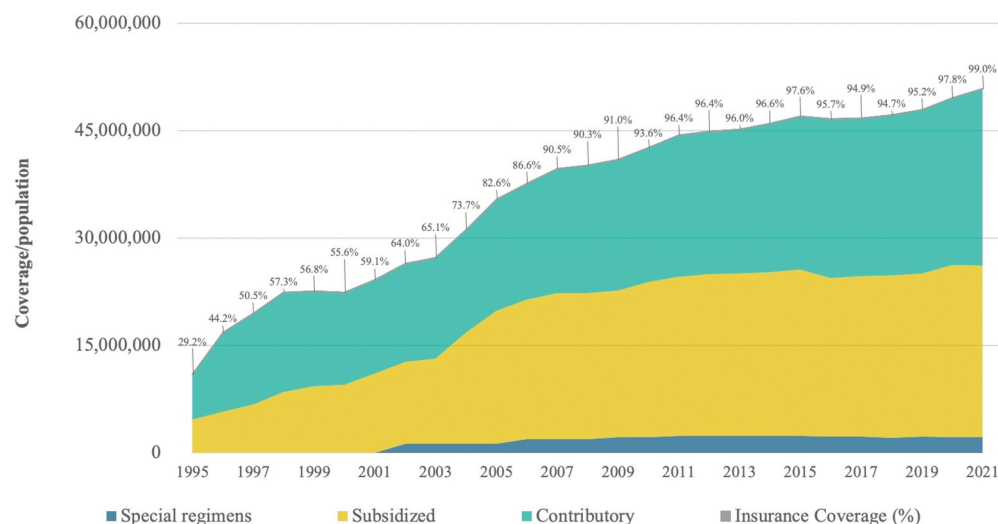


Figure 1. Insurance coverage and Colombian population covered by the SGSSS over 1995–2021. Source: Adapted from MoH, 2023.

a coherent narrative of the historical milestones and influencing factors. It will describe the institutional and governance arrangements, the development of HBPs, and the advantages and disadvantages associated with different approaches used over the past 30 years. Finally, it will discuss lessons learned, main challenges, and future perspectives.

The Health Benefits Packages in Colombia: History, Lessons, and Recommendations

The history of HBPs in Colombia over the past 30 years can be divided into two main phases based on the methodologies that inform coverage decisions. The first phase, from 1993 to 2017, focused mainly on *inclusions* due to an explicit priority-setting process via a positive list, or HBP. The second phase, starting in 2017, focused primarily on *exclusions* as a result of an explicit priority-setting process via a negative list.

In addition to using different methodologies, Colombia's health system also experimented with (and developed) different governance arrangements (i.e., who made what decisions), criteria for inclusion or exclusion, and stakeholder participation. The evolution of the priority-setting system has resulted from key decisions made by the three branches of the Colombian government: Congress, the Executive branch, and the Constitutional Court.

Phase I. An Explicit Priority-Setting Process for Inclusions (1993–2017)

The initial phase of the history of the HBPs can be divided into three distinct stages, spanning the

significant health care reform of 1993 to the enactment of the most recent major legal reform through the Statutory Law of 2015, which was subsequently implemented in 2017.⁵ At the end of every stage, we present a figure that allows the reader to understand the evolution of the priority-setting process as proposed by Gutiérrez.⁶

Stage I: Two Explicit HBPs and a Multi-Stakeholder Decision Body (1993–2007)

This first stage began in 1993 when the Colombian Congress approved the health sector reform. A cornerstone of the reform was to guarantee a package of health services for those in the contributory regime (for formal employees and their beneficiaries) and those in the subsidized regime (for those unable to contribute to the health system).

The National Social Security Council in Health (Consejo Nacional de Seguridad Social en Salud—CNSSS), a collegiate body made up of representatives from all interest groups became responsible for defining the administrative and financial roadmap of the SGSSS and for making decisions on the content of the HBPs (Figure 2). Following its legal mandate, the CNSSS established two distinct explicit HBPs. One was a larger package known as the Mandatory Health Plan (Plan Obligatorio de Salud—POS) for the contributing members of the system; and a smaller publicly subsidized HBP, known as POS-S (Plan Obligatorio de Salud—Subsidiado), which covered around 50% of the interventions included in the POS for the lower-income population under the subsidized regime. The POS was primarily based on the benefits covered by the Social Security Institute prior to the reform.⁷

	Marketing Authorization	Topic Selection	Technical Assessment	Budget Impact	Appraisal, Deliberation, Recommendation	Decision Making	Monitoring and Evaluation
Stage I	INVIMA	Limited	Limited	Limited	Limited	CNSSS	Limited

Figure 2. Health technologies assessment process and key actors before the statutory health law. Source: Authors.

The intention of the Colombian Congress when enacting the reform of 1993 was to progressively expand the breadth of POS-S, such that by the year 2000, it would include the same interventions and technologies as the POS health package. Regrettably, this ambitious objective was not achieved, mainly due to a decrease in the growth of contributing members. During the 1990s, patients started to use a new legal tool created by the recently approved Constitution of 1991, called *acción de tutela*, which allowed anyone to seek legal protection when a constitutional right is violated. Through these writs, hundreds of patients requested that judges demand that insurers cover health services and technologies that were not included in the POS or POS-S packages. Most cases ruled in favor of the plaintiffs.⁸

In this first stage, Colombia made notable improvements in expanding coverage, particularly among the poorest segments of the population. Nevertheless, during these first two decades of implementation, increasing investment in new and expensive interventions threatened both the sustainability and the equitable distribution of health services. There was also a significant health inequality among health care expenditures and social status. In 2014, less than 1% of total medication costs covered people in the poorest quintile of society, while 70% were spent on the top two wealthiest quintiles.⁹

Stage II: Unified HBP and Creation of a Decision-Making Body Attached to the Ministry of Social Protection (2007–2011)

The CNSSS was eliminated as a decision-making body in 2007 and its functions were transferred to the Health Regulation Commission (Comisión de Regulación en Salud—CRES) through the first health reform passed by Congress to modify the system since 1993 (Law 1122 of 2007).¹⁰ The new law aimed to improve the system's finances, improve the flow of resources, and clarify the roles and responsibilities of the Ministry of Social Protection, especially concerning regulation and enforcement (Figure 3).

Around the same time in 2008, the Constitutional Court issued Ruling *T-760*, a seminal decision that clarified the right to health and provided instructions to the executive branch in response to thousands of

tutelas filed by citizens before judges to protect their fundamental right to health. These writs became a systemic challenge associated with the lack of clarity, regulation, and transparency in the Colombian health system at the time.⁸ Citizens filed *tutelas* to get insurers to pay for health technologies not included in the HBPs, particularly patients in the subsidized regime, for which the HBP had no significant updates. The number of *tutelas* filed reached record numbers in 2008, almost 35 *tutelas* for every 10,000 people (Figure 4).¹¹

Stage III: Elimination of Explicit HBPs and a New Institutional Framework Based on the Right to Health (2011–2017)

In 2011, the Health Technology Assessment Agency (Instituto de Evaluación Tecnológica en Salud—IETS) was created as part of the second reform to the system since 1993 (Law 1438/2011).¹² This reform was a response to the wave of litigation to enforce the right to health, the institutional and technical limitations of CRES, and the international move to establish HTA agencies. The IETS was established as a nonprofit organization governed by a board of public and private entities, including the Ministry of Health and Social Protection (MoHSP), the Administrative Department of Science, Technology, and Innovation, the National Institute of Health, the National Institute of Drug and Food Surveillance, and the Colombian Association of Medical Schools. This institute was created to generate evidence to support decision-making within the health system, especially in relation to the HBP and standard treatment guidelines.

In addition to the creation of the HTA agency, CRES was eliminated, and a new advisory commission to the MoHSP on issues related to benefits, costs, and tariffs was created (Comisión Asesora de Beneficios, Costos y Tarifas—CABCT). The MoHSP also created a new Directorate to exclusively address the same issues within its own structure (Dirección de Beneficios, Costos y Tarifas del Aseguramiento en Salud—DRBCTAS) and to serve as the technical and administrative secretariat of the commission. Decision-making was transferred to the Minister of Health based on the advisory commission's recommendation.¹³

Overall, the explicit priority-setting process and the institutional arrangements to make coverage decisions in

	Marketing Authorization	Topic Selection	Technical Assessment	Budget Impact	Appraisal, Deliberation, Recommendation	Decision Making	Monitoring and Evaluation
Stage I	INVIMA	Limited	Limited	Limited	Limited	CNSSS	Limited
Stage II	INVIMA	CRES	CRES	Limited	Limited	CRES	Limited

Figure 3. Health technologies assessment process and key actors before the statutory health law Source: Authors.

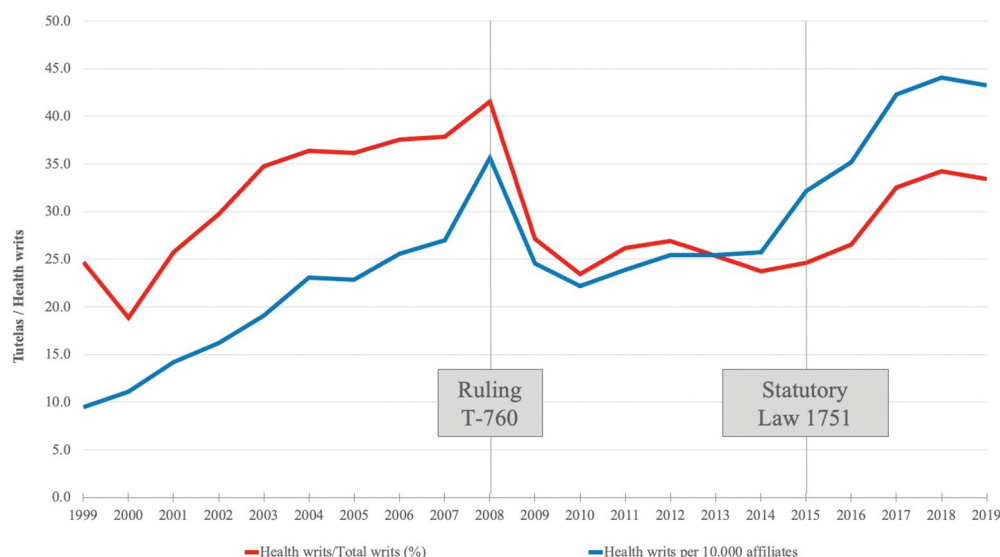


Figure 4. Health tutelas (writs) in Colombia as a proportion of the total and per 10,000 affiliates (1999–2019).⁹ Source: Adapted from Restrepo et al.¹¹ and unpublished information from Jairo Humberto Restrepo Zea.

the Colombian health system between 1993 and 2017 became more transparent and stable, and processes and methodologies more robust. More steps and a higher degree of specialization were achieved during this period (Figure 5).

Phase II: A New Exclusion Process, 2017–Present

In 2015, the Colombian Congress passed its third reform to the health system since 1993 when it

ratified the right to health as an autonomous fundamental human right through a law known as the Statutory Health Law 1751. This legislation established that financial or fiscal sustainability could not become a barrier to fully exercising the right to health. It also mandated the Colombian government to move from marginally expanding the HBP with inclusions to assuming that all health services and interventions were covered except those that meet specific circumstances.⁵

	Marketing Authorization	Topic Selection	Technical Assessment	Budget Impact	Appraisal, Deliberation, Recommendation	Decision Making	Monitoring and Evaluation
Stage I	INVIMA	Limited	Limited	Limited	Limited	CNSSS	Limited
Stage II	INVIMA	CRES	CRES	Not done	Not done	Not done	Not done
Stage III	INVIMA	MoHSP	IETS	IETS	CABCT	MoHSP	MoHSP

Figure 5. Health technologies assessment process and key actors before the statutory health law. Source: Authors.

Once the law entered into force in 2017, the MoHSP implemented a scientific and technical process for exclusions. The process incorporated consultations with groups potentially affected by any exclusion, and it had important participatory and transparency features to comply with the mandate given by the law. The new process includes the following steps¹⁴:

Nomination and prioritization: stakeholders including the MoHSP and medical associations nominate technologies for exclusion. MoHSP/DRBCTAS prioritizes nominations using criteria such as public health interest, the population affected, and budgetary impact.

Technical-scientific analysis: IETS, with the participation of independent experts from health care associations, the National Academy of Medicine, and association of schools with different health care programs, among others, must form a technical-scientific analysis group to assess and appraise the information collected and make recommendations on how convenient it is to exclude the health technology. Decisions are made by consensus.

Consultation: potentially affected patients and the public are consulted through virtual or in-person methods for 45 days.

Adoption and publication: MoHSP adopts, publishes, and implements the recommendation made during the analysis and verified during the consultation.

The technical-scientific analysis focuses on establishing whether a nominated technology or procedure fits into any of the six explicit exclusion criteria included in the Statutory Health Law, meaning if it: (1) is indicated for cosmetic purposes, (2) lacks scientific evidence on safety and efficacy, (3) lacks scientific evidence on clinical effectiveness, (4) has not been authorized by the regulatory agency; (5) is still in under clinical development; or (6) it can only be accessed in another country.⁵ By June 2023, the negative list approved by Resolution 2273 already included 97 items (pharmaceuticals, procedures, and non-medical products or services).¹⁵ It should be noted that this represented a small minority of less than 1% of technologies approved by the regulatory agency.

Discussion

Since 1993, when the World Bank published the World Development Report and called for a minimal package of essential health services, several low- and middle-income countries (LMICs) have institutionalized evidence-informed priority-setting processes to explicitly identify priorities and define a basket of services or HBP.¹⁶ By contrast, several high-income countries (HICs) have

institutionalized evidence-informed priority-setting practices at the margin. This involves deciding whether to include or exclude new health technologies from an already comprehensive and historically expansive set of benefits shortly after their market entry. These differences have led LMICs, for the most part, to develop positive lists, and HICs to develop negative lists. As LMICs grow richer and try to expand coverage, there has been pressure from citizens and reference groups like the OECD to move to negative lists. In 2016, the OECD explicitly advised the Colombian government to “define the basic package as a list of exclusions, rather than inclusions.” This would, in theory, reduce judicialization as all medically safe technologies would be assumed to be covered by the health system unless explicitly excluded from the HBP. The OECD report also provided examples of how other LMICs and HICs restricted spending on less cost-effective technologies using exclusion lists.¹

The HBPs have been a key policy instrument for Colombia to improve coverage and work toward universal health coverage since the major health sector reform in 1993. Governments successfully used HBPs to create explicit, legal entitlements for Colombians by determining which services would be available and to whom. Also, the HBP was used to calculate the premiums paid to insurers and signal priority services to clinicians and patients. Over time, institutional arrangements became clearer and more stable, and processes and methodologies more robust. Patient and civil society groups were also increasingly included in the process.

However, the limitations set by the HBP may have made clinicians feel that the HBP constrained their autonomy, patients could have perceived that key technologies were not included without further explanation, and insurers might have used the HBP to deny care. Meanwhile, Colombians also embraced the right to health enshrined in Statutory Law as a robust human rights framework for considering health care within the country. These social pressures prompted a shift from an inclusion-based priority-setting system, to an open approach with minimal exclusions.

This change has raised significant concerns. Issues of transparency, legitimacy, and financial sustainability surface as patients and health care providers may presume that all technologies and services are covered. However, the reality is that neither health care expenditure nor the premium paid to insurers have increased to accommodate a scenario where all theoretically covered services translate into services received by patients. Furthermore, as new technology and medications come to market, the review for exclusion may take time to occur. This delay in exclusion may expose insurers to an increased early

demand for high-cost technologies and interventions. In response to this, some insurers are likely to impose access barriers and/or resort to individual biased discretion (implicit rationing) to limit the use of potentially necessary health care resources. Implicit rationing, a lack of essential services in some regions, and the risk of favoring new, high-cost technologies in urban areas might also lead to increased health care inequity. Lastly, because cost-effectiveness cannot be used as an exclusion criterion, some technologies and medications may not present a greater benefit to society compared to cost.

However, moving from a positive to a negative list has brought some benefits. It has provided clarity to all stakeholders that insurers cannot deny health services because these were not listed in the HBP. It has promoted medical autonomy by allowing health care professionals to prescribe the appropriate medical care without additional bureaucratic and administrative barriers. It has reduced the costs and efforts of patients who previously had to go through the courts or lengthy approvals to access care. Insurers were also able to better manage their clinical and financial risk by receiving funding ahead of time based on estimates rather than seeking reimbursement after treatments were paid out.

In short, the shift from a positive to a negative list has created tension between two views: one that embraces health as a fundamental human right, and, when taken to the extreme, argues that health care must be guaranteed regardless of the funds available and financial considerations, and the other view, which argues that available funding must determine what is covered and that value for money should be maximized for any budget.

A Way Forward

As the Colombian government looks for policy options to replace the HBP as a tool to determine priorities within financial means, while also guaranteeing a system that delivers on the promise of health as a fundamental human right, a few potential options can be considered. These alternative policy options are far from perfect and are tailored to fit the existing health system design in the country. They don't consider the substantial changes proposed by the government of Gustavo Petro, who seeks to transition toward a national health system with a single payer. The proposed reform also includes a payment mechanism based on a national fee schedule set by the government for both private and public providers, along with a significant increase in funding for the public health-care infrastructure. However, notably absent from the proposal is any consideration for a priority-setting mechanism.

Strengthening Priority-Setting at Lower Levels within the Health System

In the absence of a centralized priority-setting process, insurers and health care providers could conduct their own evaluations and decisions regarding covered benefits and associated costs. Although less efficient, a lower-level strategy could increase health care quality and make these stakeholders better stewards of public funds. Implementing this approach would allow for potentially quicker responses, localized strategy, and an increased reach and impact.⁶

Alternative Processes to Deal with Health Technologies with Low Cost-Effectiveness

Even though economic evaluation cannot be conducted and used by the MoHSP to exclude products on cost-effectiveness grounds, these methodologies should be applied for other purposes, including price regulations and negotiations, as well as the development of standard treatment guidelines and protocols. The MoHSP would benefit from deploying horizon scanning and early negotiation techniques, such as managed entry agreements, to avoid high-cost products from entering the Colombian market without adequate stewardship. The MoHSP could also apply co-payments to services and technologies with low health value to signal the market and stir demand.

Deploying Alternative Options for Funding Insurers

Adequate incentives to steer insurers to better manage clinical and financial risk and deliver high-value quality care should be implemented. These could include changing how the premium is calculated by incorporating outcome-based indicators and conditions. It also involves better ex-ante and ex-post adjustments to reduce risk asymmetries and address risk concentration in the populations covered by certain insurers.

Increasing Efficiency in the System

Inefficiencies in the form of excess costs in producing a given output should be tackled. Demand aggregation and centralized procurement of expensive technologies, increased use of generic and biosimilar medicines, tackling waste, corruption, and fraud, etc., would help the system achieve more health for the money.

Improving Monitoring and Evaluation

Systematically and routinely measuring the services provided and the quality of such services would help the MoHSP measure effective coverage and identify and

address implicit rationing or signal inadequate or inefficient consumption patterns. The MoHSP already collects information on services provided to calculate the premium but capturing additional attributes and improving data quality is needed.

Strengthening Stakeholder Participation

Despite improvements in engaging stakeholders in specific processes such as determining exclusions, it is vital to increase effective engagement in fundamental discussions such as the financial sustainability of the system, the importance of maximizing health benefits, of following priority setting at certain levels (clinical practice guidelines and protocols), and the need to incorporate new technologies at fair prices.

Conclusion

Priority setting in Colombia has evolved over the past thirty years. During this period, benefits have changed from an inclusionary list to an implicit approach that covers, in theory, everything for everyone, excluding a narrow negative list of services and health technologies. Both approaches came with advantages and disadvantages. In thirty years, institutions were created and terminated while processes and methodologies became more transparent and stable. However, methodologies still have limitations as the concept of opportunity cost is not adequately embedded into decision-making.

Colombia's evolution provides several lessons for other LMICs interested in institutionalizing evidence-based priority-setting. Its successes and failures can help to inform current and future discussions on how to pursue universal health coverage.

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