Governance and guarantee of the right to health: the case of Colombia

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Gobernanza y garantía del derecho a la salud: el caso de Colombia

Governança e garantia do direito à saúde: o caso da Colômbia

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Highlights

- Governance is a highly relevant concept grounded in governability, which originates in the exercise of government.
- In the health system, governance is characterized by the tension between a robust regulatory framework and insufficient operational capacity to implement it effectively.
- Accountability currently follows a formalistic approach centered on regulatory bodies, weakening social oversight and resulting in low-stringency targets.
- The government misconstrues the concept of health insurance by reducing it to the role of health insurance providers, even though it is a function of the health system as a whole.

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Abstract

Introduction: Governance refers to the way in which decisions affecting public affairs are made, particularly within the health system and in resource management. It should be binding and promote co-management among actors involved. In this way, governance contributes to state-building and the strengthening of citizenship. **Objective:** To analyze the governance process of the General Social Security System in Health from the perspective of the decision-making by the actors involved in a case study, through the assessment of norms, nodal points, and processes, to ensure the Colombian population's right to health. **Materials and Methods:** A case study using a descriptive-interpretive qualitative approach was conducted based on semi-structured interviews with sixteen key actors in the health system. Qualitative analysis drew on analytical tools from grounded theory and followed the theoretical principles of the Governance Analytical Framework. **Results:** Participants indicated that stewardship of the General System of Social Security in Health has weakened and that citizen participation has become limited, affecting the guarantee of the fundamental right to health. **Discussion:** The study recognizes that shortcomings in the governance of the General System of Social Security in Health are not solely associated with system stewardship; therefore, multilevel analytical frameworks for governance are needed to inform proposed reforms. **Conclusion:** There is a recognized need to rebuild state capacities, strengthen territorial governance, and reestablish mechanisms for broad participation in order to move toward a health system oriented toward guaranteeing the fundamental right to health.

Keywords: Governance; Corruption; Health System; Health Care Models; Barriers to Access to Health Services.

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Gobernanza y garantía del derecho a la salud: el caso de Colombia

Resumen

Introducción: La gobernanza se refiere a la forma en que se toman decisiones que inciden en lo público, particularmente en el sistema de salud y gestión de recursos. Debe ser vinculante y fomentar la coadministración entre actores involucrados. Así, contribuye a la construcción del Estado y al fortalecimiento de la ciudadanía. **Objetivo:** Analizar el proceso de gobernanza del Sistema General de Seguridad Social en Salud desde la toma de decisiones de los actores involucrados en un estudio de caso mediante la evaluación de las normas, puntos nodales y procesos, con el fin de garantizar el derecho a la salud de la población colombiana. **Materiales y Métodos:** Se realizó un estudio de caso con enfoque cualitativo descriptivo-interpretativo, basado en entrevistas semiestructuradas a dieciséis actores clave del sistema de salud. El tipo de análisis cualitativo correspondió a herramientas analíticas de teoría fundamentada siguiendo los principios teóricos del Marco Analítico de la Gobernanza. **Resultados:** Los participantes señalan que la rectoría del Sistema General de Seguridad Social en Salud se ha debilitado y la participación ciudadana se limitó, incidiendo en la garantía del derecho fundamental a la salud. **Discusión:** La investigación reconoce que las fallas en la gobernanza del Sistema General de Seguridad Social en Salud no están únicamente asociadas a la rectoría del sistema, por ende, se requieren marcos de análisis multinivel de la gobernanza para proponer reformas. **Conclusión:** Se reconoce la necesidad de reconstruir capacidades estatales, fortalecer la gobernanza territorial y reestablecer mecanismos de participación amplia para avanzar hacia un sistema de salud orientado a la garantía del derecho fundamental a la salud.

Palabras Clave: Gobernanza; Corrupción; Sistemas de Salud; Modelos de Atención de Salud; Barreras de Acceso a los Servicios de Salud.

Governança e garantia do direito à saúde: o caso da Colômbia

Resumo

Introdução: Governança refere-se à forma como as decisões que afetam os cidadãos são tomadas, particularmente no âmbito do sistema de saúde e da gestão de recursos. Ela deve ser vinculativa e fomentar a cogestão entre os atores envolvidos. Portanto, deve contribuir para a construção do Estado e o fortalecimento da cidade. **Objetivo:** Analisar o processo de governança do Sistema Geral de Seguridade Social em Saúde, com foco na tomada de decisões dos atores envolvidos em um estudo de caso, por meio da avaliação de regulamentos, componentes-chave e processos, a fim de garantir o direito à saúde da população colombiana. **Materiais e Métodos:** Foi realizado um estudo de caso utilizando uma abordagem qualitativa descritiva-interpretativa, baseada em entrevistas semiestruturadas com atores-chave do sistema de saúde. A análise qualitativa empregou as ferramentas analíticas da teoria fundamentada, seguindo os princípios teóricos do Quadro Analítico de Governança. **Resultados:** Os participantes percebem que a governança do Sistema Geral de Seguridade Social em Saúde está fragilizada e a participação cidadã é limitada, o que afeta a garantia dos direitos fundamentais à saúde. **Discussão:** A pesquisa reconhece que as deficiências na governança do Sistema Geral de Seguridade Social em Saúde não estão associadas apenas à gestão do sistema; portanto, são necessários marcos de governança multinível para propor reformas. **Conclusão:** Reconhece-se a necessidade de reconstruir as capacidades do Estado, fortalecer a governança territorial e restabelecer mecanismos para maior participação, a fim de promover um sistema de saúde orientado para a garantia dos direitos fundamentais à saúde.

Palavras-Chave: Governança; Corrupção; Sistema de Saúde; Modelos de Cuidados de Saúde; Barreiras ao Acesso aos Serviços de Saúde.

Introduction

Health governance is understood as the process through which diverse actors interact in decision-making and in the development of normative frameworks related to health policies[1–3]. In Latin America, analytical frameworks have been developed to examine these processes in local contexts; however, the literature also points to a lack of conceptual consistency in the terminology used and to structural barriers to the effective implementation of comprehensive health policies[4–6]. The most influential contribution is Marc Hufty's Governance Analytical Framework (GAF), which proposes analytical units such as problems, actors, norms, processes, and nodal points to examine interactions among the actors involved in decisions concerning the direction of the General System of Social Security in Health[7,8].

This approach has been applied in Latin America to examine power dynamics and decision-making mechanisms within health systems, showing that the participation of diverse actors can democratize local governance and transform the design and implementation of public policies, particularly when mechanisms for collaboration, community participation, and interinstitutional coordination are in place[9,10]. Limitations have also been identified, including weak user participation, centralized decision-making, institutional fragmentation, insufficient coordination across levels of government, and shortcomings in stewardship, leadership, technical capacity, and financial management, all of which affect policy formulation and implementation as well as the development of integrated health service networks[11–13.]

These dynamics create tensions between the formal principles of health systems and the actual decisions made by actors in contexts characterized by high levels of social inequality and resource constraints[14–17]. Accordingly, the study of governance has gained increasing relevance as a means of establishing guidelines to improve health system performance and health-related decision-making[18–20].

Although the literature on health governance in Latin America has grown substantially, studies that examine in detail the decision-making processes among key actors within specific health systems remain scarce, particularly in Colombia's General System of Social Security in Health (SGSSS). This reflects a knowledge gap and limits understanding of how power relations, particular interests, and political considerations affect the system's capacity to guarantee the right to health recognized under Law 1751 of 2015[21].

In this context, this article aims to analyze the governance of the SGSSS based on the decisions of the actors involved, applying Hufty's conceptual framework. It seeks to understand how governance dynamics affect the guarantee of Colombians' right to health and why, despite the existing legal framework, access problems associated with political decisions about the system's functioning persist. Accordingly, this study addresses the following research question: How does the governance process unfold within the SGSSS to guarantee the Colombian population's right to health under Law 1751 of 2015?

Materials and Methods

This study used a descriptive-interpretive qualitative approach[22] grounded in the constructivist paradigm[23]. The study was guided by a hermeneutic and dialectical logic, and the findings were analyzed using grounded theory analytical tools to code, categorize, and relate the data in order to develop a theoretical understanding of the phenomenon under study[24].

The methodological approach adopted in this study was an intrinsic case study[25] of the Colombian health system, examined from a governance perspective to identify the political issues, barriers, and

factors that influence decisions regarding the guarantee of the right to health within the framework of Law 1751 of 2015.

Convenience sampling[26] was initially used to recruit key participants for the first phase of the study. Subsequently, in response to emerging analytical needs, the sampling strategy evolved into theoretical sampling[27], allowing the selection of participants with relevant characteristics to deepen understanding of the categories emerging during the analysis. The sample was progressively expanded from eight to 16 participants, at which point theoretical saturation was reached, defined as the stage at which no new elements emerged within the analytical categories in terms of either their properties or dimensions[28].

The inclusion criteria were: (a) direct or indirect involvement in the SGSSS; (b) representation across different affiliation levels; (c) diversity of professional roles (managerial, operational, technical, and administrative); (d) willingness to participate and provide signed informed consent; and (e) academic background and level of leadership. Potential reasons for participant loss were: (a) evident alterations in mental status, lack of orientation, and impairment of recent or remote memory; and (b) impairments in the comprehension or expression of spoken language. Interviews were conducted between May 2024 and May 2025 and lasted an average of 62 minutes.

The sixteen participants were involved in decision-making related to the SGSSS and health policy, primarily at the national level. Ten of the interviewees were men; most had academic backgrounds in the health field and experience in the leadership or management of health services, ranging from 20 to 50 years, and four held doctoral degrees. Ten strategic actors occupying formal positions within the SGSSS were identified; these actors mobilize different forms of capital within the health system, understood as a social field. These forms of capital include economic capital (monetary resources), social capital (networks and organizations), cultural capital (knowledge of the system), and symbolic or interest capital (recognition, perceptions, and social values)[29]. Actors with a moderate level of influence, in turn, participate in decisions or policies with a local scope Table 1.

Table 1. Participants' characteristics

Actor No.	Participant ID	Actor type	Affiliation level	Academic background	
				Health-related studies	Postgraduate degree
1	EN1VPS-1	S	N	Yes	Yes
2	EN2ANSP	S	N	Yes	Yes
3	EN3ONG-1	I	I		Yes
4	EN4IPS	I	N		Yes
5	EN5SDS	S	D	Yes	Yes
6	EN6ONG-2	S	I	Yes	Yes
7	EN7MS-1	S	N		Yes
8	EN8VPS-2	S	N		Yes
9	EN9MS-2	S	N	Yes	Yes
10	EN10EPS	S	N		Yes
11	EN11SOCIV-1	I	N	No	No
12	EN12EXP-1	I	N		Yes
13	EN13SOCIV-2	I	N	No	No
14	EN14VPS-3	S	N	No	Yes
15	EN15ASOGRE	S	N		Yes
16	EN16EXP-2	I	N	Yes	Yes

S: Strategic; I: Actor of interest. N: National; D: Departmental; I: International

The interview guides were developed in accordance with the theoretical and methodological principles of the GAF[7,8], under the supervision of the advisory committee. The guides were pilot-tested with two health institution executives, which allowed the instrument to be validated Table 2.

Table 2. Categories used to design the interview guides

Thematic unit	Analytical category	Analysis subcategories
1. Actors (They are capable of making decisions and influencing processes and may be strategic, secondary, or relevant actors.)	1. Health system actors	Characteristics of actors that determine their level of participation in the governance process: gender; actor type (strategic or interest); academic and managerial background; leadership, administrative, and governance capacity; international, national, departmental, or municipal level of authority; and power resources.
2. The problem (Refers to what is at stake, in this case, the governance of the SGSSS.)	2. The problem from a governance perspective	To analyze the governance process of the General System of Social Security in Health from the perspective of actors' decision-making, through the assessment of norms, nodal points, and processes.
3. Norms (Construction of the rules of the game among actors that explain their decisions.)	3.Formal: normative framework	Set of formal norms and/or meta-norms and constitutive norms (laws, norms, and regulations) that guide actors' decisions and/or behavior.
	3. Informal: values and beliefs	Set of informal and/or regulative norms (systems of social values and beliefs) that guide actors' decisions and/or behavior.
4. The process (Sequences of states through which a system passes, allowing assessment of the direction in which these processes evolve.)	4. Decision-making process	Level of participation in policy formulation, participation, and implementation within the governance process.
5. Nodal points (Physical or virtual spaces where decision-making processes, actors, and norms converge.)	5. Formal and informal engagement	Extent to which actors are convened in formal and informal spaces and their response in terms of participation by diverse sectors of society in the formulation of policies aimed at the governance of the SGSSS.
	5. Participation	Mechanisms or forums in which decisions are made to guarantee the right to health.
	5. Node levels	Level of actor participation, with or without voice and voting rights.
	5. Transparency and accountability	Transparency is based on the free flow of information; institutional processes and information should be directly accessible to interested parties, and sufficient information should be provided to understand and monitor health-related matters.

The methodological rigor criteria[30] used to assess the scientific quality of the study were: (I) credibility: established through triangulation by three independent coders, member checking, and the use of thick descriptions supported by verbatim excerpts; (II) auditability: the advisory committee reviewed the data and reached conclusions that were the same as or similar to those of the researchers; and (III) Transferability: achieved when the data generated by the study were representative and had the potential to be useful and applicable to other studies.

Data analysis required a detailed examination of all interviews through the analysis, comparison, and categorization of the data[31]. Coding was conducted in three stages. First, open coding yielded 13 descriptive categories derived from 1,030 codes[32]. Second, axial coding yielded four analytical categories. Finally, selective coding resulted in a core category corresponding to the phenomenon under study. To strengthen methodological transparency, the researchers recorded and systematically organized the information using Microsoft Office tools. In qualitative research, researchers themselves are recognized as the primary instruments, as they interpret the findings and construct their hermeneutic meaning.

Thus, credibility does not depend on the use of specialized software but rather on analytical rigor, triangulation, and the constant comparative method[33]. In this study, Word was used for coding and Excel for organizing the categories, consistent with the data analysis process[34-36].

This study adhered to the ethical principles established in Resolution 8430 of 1993 of the Colombian Ministry of Health. The study was approved by the Ethics Committee of the Graduate School of CES University, as documented in Minutes No. 190 dated April 4, 2022, based on the measures established by the researcher to protect participants' dignity and privacy. The complete dataset collected in the study is publicly available in Mendeley Data[37].

Result

This section describes the thematic categories that emerged from the interviews, the four interrelated themes, and the core category, *"More Governance and Less Governability,"* which together constitute the theoretical approach for addressing the research question.

Descriptive categorization

In the first phase, thirteen analytical categories were identified. The model of care category accounted for the largest number of codes (n = 204), followed by government management (n = 114) and citizen participation (n = 108), suggesting that the organization and management of health care, together with opportunities for participation, constitute central dimensions for understanding governance within the SGSSS. Similarly, categories such as access to health services, health sector agents, control and regulation, and the right to health were also prominent, indicating that experiences of using the health system and the actions of the different actors substantially shape participants' accounts.

The initial categorization highlights the complexity of SGSSS governance: while themes such as access and the right to health predominate, less frequent categories—such as territorial management and corruption—capture critical experiences that complement the analysis in subsequent phases Figure 1.

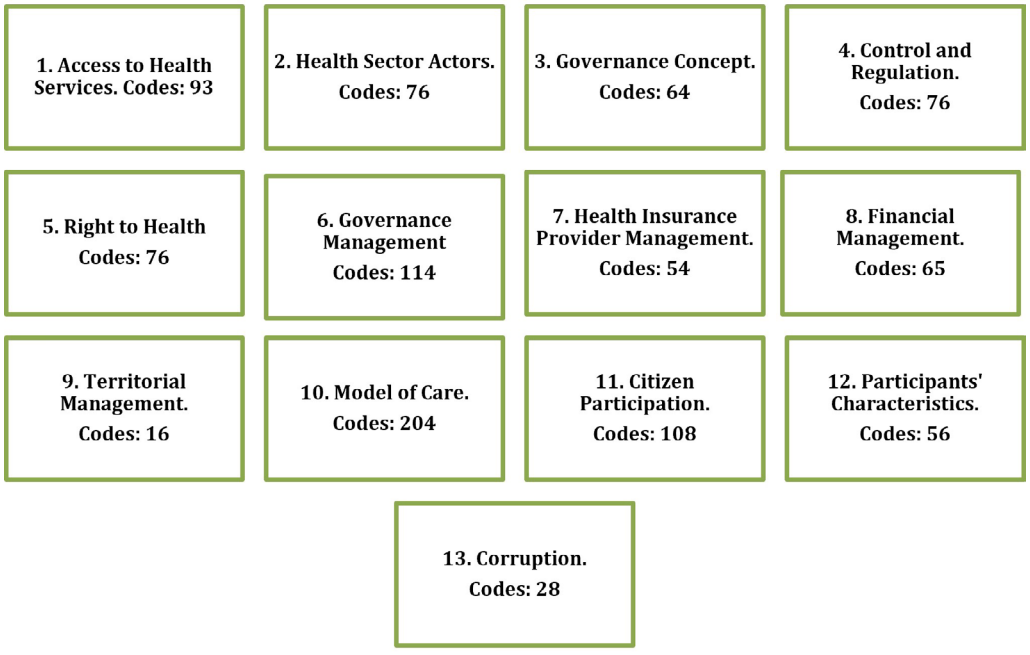


Figure 1. Descriptive categories

Analytical categories

During the axial coding phase, four analytical categories were developed based on the relationships among the descriptive categories Figure 2 presents the first analytical category.

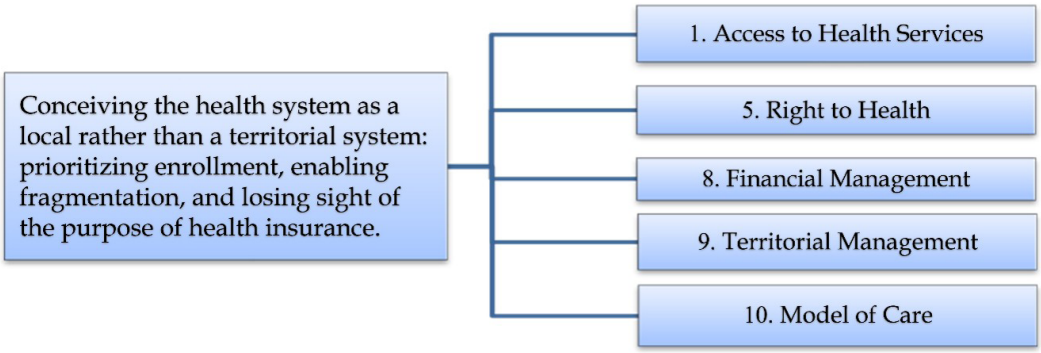


Figure 2. First analytical category

The current model has been conceived as a local health system rather than a territorial health model. The former prioritizes enrollment and provides services based on an individual's insurance coverage, whereas the latter delivers care where individuals live and develop both biologically and socially. This has distorted the model, leading to geographic, socioeconomic, and administrative barriers. In other words, government centralization, together with a lack of multilevel coordination, results in insufficient technical assistance for territorial entities. Excerpts from the interviews are presented below:

> *"The main barrier in the old model… is this model of local territorial health systems—population silos versus territorial silos… So, if Sura or Sanitas goes into a neighborhood, you end up needing three or four teams, each from a different insurer. No, there should be just one. The response should be territorial, not based on where someone is enrolled. That's a distortion, and it creates barriers to access."* (EN16EXP-2)

> *"The main barrier today is geographic… Services are heavily concentrated, especially highly specialized services, in the major cities."* (EN10EPS)
> *"There are limitations when it comes to access… I'm talking about the health workforce… Our geography is so challenging that it's difficult for a medical specialist to build a life in remote parts of Colombia—to raise their children, have a family… Specialists simply aren't going to go there."* (EN8VPS-2)

Figure 3 presents the second analytical category.

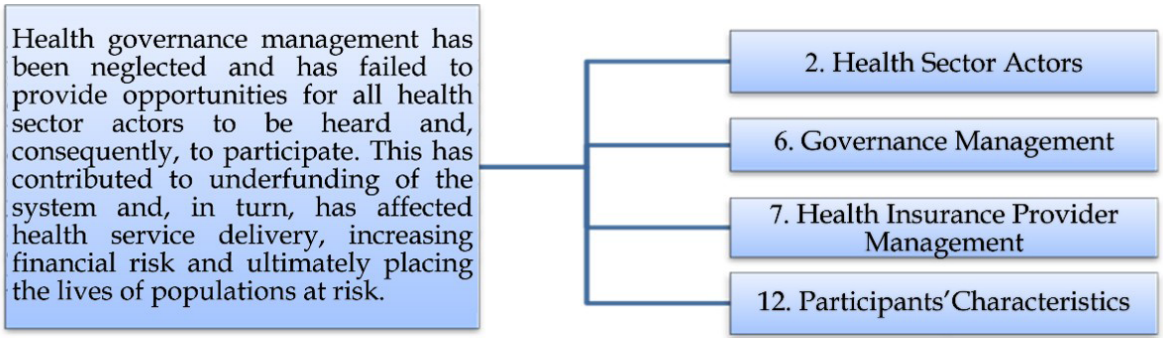


Figure 3. Second analytical category

Intersectoral collaboration and the participation of all health system actors are needed to develop action plans with transparent monitoring and accountability mechanisms that enable a structural assessment

of the health system's long-term financial viability. Sustainability should also be addressed through a clear vision that allows the system to continue evolving. This requires defining where the system is headed, identifying its starting points, and determining the areas that need improvement in order to maintain a system that continues to contribute to population health. Excerpts from the interviews are presented below:

> *"…There was a regulatory failure from the very beginning. There were no real solvency requirements to ensure that the EPS maintained capital and liquidity and recorded their technical reserves…"* (EN8VPS-2)

> *"It's not that the Ministry doesn't listen to civil society; it's that it doesn't listen to Pacientes Colombia… They won't meet with us… They've seen our voice not as a constructive one, but as a voice of opposition, and that has made it extremely difficult for us to participate in those spaces."* (EN13SOCIV-2)

Figure 4 presents the third analytical category.

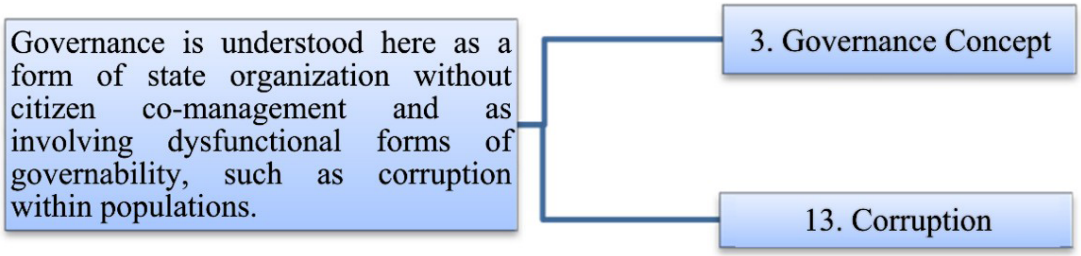


Figure 4. Third analytical category

Governance is associated with the State and involves a process of decision-making under centralized policies formulated and coordinated by the highest authorities, whereas governability is associated with government. Senior authorities exercise their power to convene representatives of the SGSSS and other actors with a social interest. Strengthening governance requires granting greater autonomy to decision-makers to formulate and co-manage their policies and to implement strategies in a coordinated, collaborative manner with both national actors and civil society organizations. Incorporating social actors within the local context, including civil society organizations, helps ensure that policies are comprehensive and sustainable over the long term, while also fostering the values of equity, reciprocity, shared responsibility, and solidarity. In short, governance entails a binding process.

Such a climate of trust would foster greater commitment and accountability among actors while strengthening transparency and accountability mechanisms. Otherwise, it can be inferred that there is confusion regarding decision-makers' levels of responsibility and that the scope of their decisions is limited, creating conditions for corruption and clientelism to emerge as dysfunctional forms of governability. Excerpts from the interviews are presented below:

> *"…with weak oversight, and it all depends on the judgment of the official who authorizes the spending… So we have a system that is highly vulnerable to corruption…"* (EN1VPS-1)

> *"Governance and governability are also connected to another concept: citizen empowerment… This also means that the government gives up some of its power, while citizens gain power."* (EN16EXP-2).

> *"Actors take part in government processes, public policy processes, planning, implementation, formulation, and evaluation, but their participation is not binding… Governance means that participation has to be binding."* (EN16EXP-2).

Figure 5 presents the fourth analytical category.

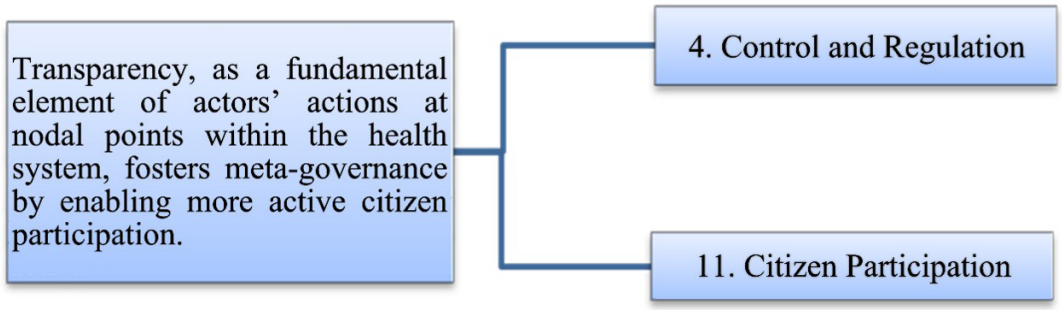


Figure 5. Fourth analytical category

Greater transparency does not imply an absence of authority, but rather a reconfiguration of power relations in which legitimacy is built through openness, dialogue, and accountability. Trust among actors in physical and virtual spaces shapes their decisions and actions, thereby facilitating more distributed and participatory governance to address health issues from a more comprehensive perspective that incorporates citizens' experiences. This represents an open and flexible model of governance that facilitates citizen empowerment while the State deconcentrates its stewardship role within the system. Consequently, strengthening transparency contributes to the sustainability of metagovernance, understood as a higher level of coordination and collective learning that enables the system to self-regulate, innovate, and adapt. Excerpts from the interviews are presented below:

> *"Some actors say that the government's role should be to foster governance processes… but the government doesn't do that because it's not in its interest. The structure is vertical: stewardship, the health secretariat, the Ministry of Health—and citizens are way down at the bottom. Patients are down there as passive recipients."* (EN9MS-2).

> *"…Metagovernance is about creating conditions, from a life-course perspective, to influence the determinants—that is, enabling individuals to change their environment… in other words, to gain political autonomy."* (EN16EXP-2)

> *"Citizens don't know that whole range of entities; they don't have access to that. So that's part of the government's role… to provide metagovernance…"* (EN16EXP-2).

The analytical categories, integrated through selective coding, yielded a final interpretation articulated as a theoretical approach to the research question: "More Governance and Less Governability" Figure 6.

The governance of the Colombian health system is one of the most significant challenges for national and subnational governments, given the mixed nature of the health system model. Participants indicated that stewardship of the SGSSS has undergone a process of weakening that has affected the organization of services, financing, and the guarantee of the fundamental right to health. According to participants, the government has restricted opportunities for citizen participation, undermining the legitimacy of decision-making. This situation further reinforces geographic, economic, and social inequalities. It is therefore necessary to rebuild state capacities, strengthen territorial governance, restore health authority, and reestablish mechanisms for broad participation that enable a transition toward *"more governance and less governability."* This does not imply a loss of state control, but rather an evolution toward a model of SGSSS governance based on the principles of inclusion, collaboration, and transparency, one that grants political autonomy to actors and strengthens decentralization within the health system.

Within the health system, governability refers to the State's capacity to steer and regulate the system, ensure regulatory compliance, and exercise stewardship. In contrast, governance refers to processes of interaction, coordination, and negotiation among system actors, as well as to the institutional arrangements and rules of the game that enable the collaborative, efficient, and transparent formulation and implementation of policies aimed at guaranteeing the right to health.

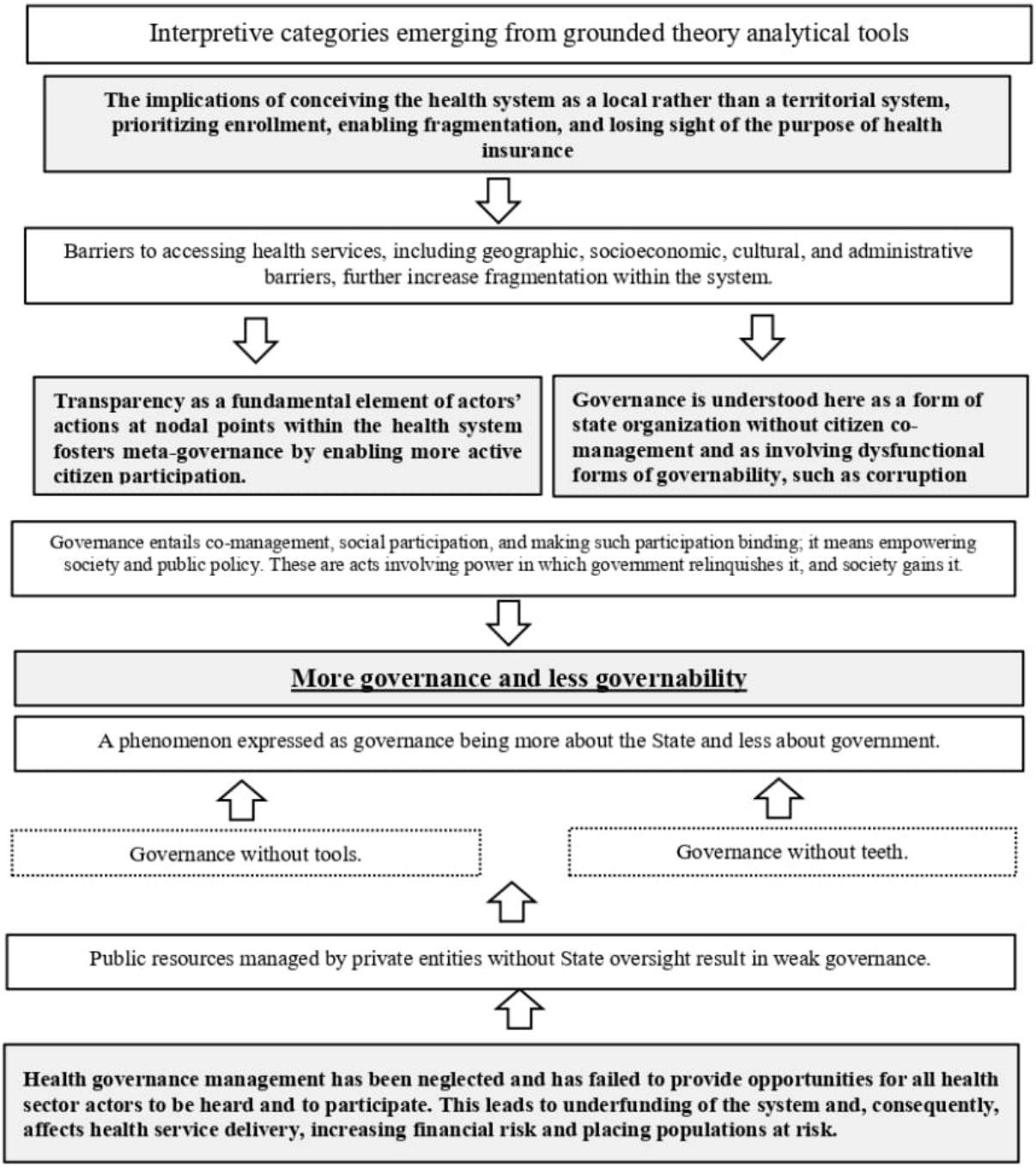


Figure 6. Theoretical approach to addressing the research question

Discussion

Among the study findings, participants identified the need to reform the SGSSS because, as recognized in studies such as that by López-Mallana et al.[38], barriers to access persist across territories due to the high concentration of health services in major cities. In 90% of the national territory, the system lacks the capacity to meet the population's health needs, particularly in rural areas, where patients discontinue medical treatment because of administrative processes and difficulties monitoring their health status[38]. These conditions reflect market and policy failures arising from the governability and governance of the SGSSS and represent a key determinant of system operations and relationships among actors[39,40]. However, shortcomings in SGSSS governance are not solely associated with stewardship. Therefore, health governance analytical frameworks that focus exclusively on regulation, such as those proposed by Vian et al.[41] and Cleary et al.[42], provide a limited perspective because governance is a multidimensional concept[43]. In this regard, multilevel frameworks, such as those proposed by Hufty et al.[7] and Hufty[8], Abimbola et al.[44], Brinkerhoff and Bossert[45], and Siddiqi et al.[46], provide a more appropriate analytical approach.

According to Hernández Flórez[3], governance has deeper implications for citizens' role in health, whereas governability is more institutionally oriented. Therefore, treating these concepts as equivalent undermines the construct of governance as a means of building a stronger State. In this regard, the GAF enables analysis of the components of SGSSS governance by identifying the levels of responsibility of actors involved in health policy and distinguishing between the capacity to govern (governability) and decision-making and coordination mechanisms (governance). The scope of this study does not reveal the interrelated nature of the five governance dimensions of the TAPIC framework—Transparency, Accountability, Participation, Integrity, and Capacity[47]. Nevertheless, the GAF enables analysis of the interactions among actors, norms, and processes within the health sector.

In summary, the SGSSS requires more governance spaces with binding decision-making capacity. The aim is not to replace government but to strengthen State policies in the health sector. This underscores the need for an analytical framework for the system that does not focus solely on transparency. In other words, a multidimensional approach is proposed to support a reform that incorporates the demands of all actors.

Limitations

The recruitment process was delayed because of participants' demanding schedules and, in some cases, the need to coordinate in advance with their advisors. Acceptance of the interview invitations took between one and four months.

Conclusions

This study is highly relevant to the policy debate on reforming the Colombian health system, as it reveals shortcomings in the governance process of the SGSSS that contribute to the persistence of health inequities. The steering and decision-making processes of the Colombian health system have limited participation by multiple actors, undermining the legitimacy of decisions and the system's collective intelligence, given that decision quality improves when exchanges occur among diverse nodes. As the SGSSS is a complex system, broad participation is required for its effective management.

Stewardship of the SGSSS has weakened, a process associated with the operation of a mixed model involving both the market and the State, with implications for service delivery, financing, and the

guarantee of the fundamental right to health. Consequently, health system governance has become one of the major public policy challenges in Colombia. The erosion of stewardship represents a governance problem because of the limited capacity to coordinate integrated networks, manage information, regulate the system's solvency, and oversee service quality. This gap in State capacity calls for analytical frameworks that examine the problem from a multidimensional perspective. In this regard, frameworks that facilitate comprehensive assessment can inform the design of relevant SGSSS reforms and public policies.

Moreover, the lack of transparency in the health system creates information asymmetries. Facilitating citizen participation and influence in decision-making through access to information can therefore enhance their role in shaping the direction of the SGSSS and its reform, whether through oversight of resource use or participation in established forums for discussion and consensus-building.

Finally, there is an urgent need to rebuild State capacity, strengthen territorial governance, restore the health authority, and reestablish mechanisms for broad participation to move toward a health system that fully guarantees the fundamental right to health.

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Author contributions: DOR-C: Conceptualization; Data Curation; Formal Analysis; Investigation; Project Administration; Writing-Original Draft Preparation. ICP-Z: Methodology; Resources; Validation; Visualization. PA-F: Supervision; Writing-Review & Editing.

References

1. **Mandl Stangl J.** Gobernanza de políticas públicas saludables en los ámbitos locales: una propuesta para el debate. *Cuadernos del CENDES.* 2017;34(96):65-86. https://www.redalyc.org/articulo.oa?id=40354944003
2. **Rodríguez C, Lamothe L, Barten F, Haggerty J.** Gobernanza y salud: significado y aplicaciones en América Latina. *Rev Salud Pública.* 2010;12(1s):151-159. https://revistas.unal.edu.co/index.php/revsaludpublica/article/view/33507
3. **Hernández Flórez LJ.** La gobernanza en la salud: un término arrebatado a la ciudadanía. La Silla Vacía. 2024. Consulta: julio 10, 2025. Disponible en: http://www.lasillavacia.com/red-de-expertos/red-de-ciencia-e-innovacion/la-gobernanza-en-la-salud-un-termino-arrebatado-a-la-ciudadania/
4. **Lopez-Zambrano JY, Liccioni EJ.** Principios de la nueva gobernanza en la administración pública. Una oportunidad para la transparencia en el sector salud.: Unidad de estudio: Hospital del IESS de Manta. 593. *Digital Publisher CEIT.* 2023;8(3-1):36-51. https://doi.org/10.33386/593dp.2023.3-1.1844
5. **Báscolo E.** Gobernanza de las organizaciones de salud basados en Atención Primaria de Salud. *Rev Salud Pública.* 2010;12(1s):8-27. https://revistas.unal.edu.co/index.php/revsaludpublica/article/view/33450

6. **Repullo JR, Freire JM.** Gobernabilidad del Sistema Nacional de Salud: mejorando el balance entre los beneficios y los costes de la descentralización. Informe SESPAS 2008. *Gac Sanit.* 2008;22:118-25. https://doi.org/10.1016/S0213-9111(08)76083-7
7. **Hufty M, Báscolo E, Bazzani R.** Governance in health: a conceptual and analytical approach to research. *Cadernos de Saúde Pública.* 2006;(22):35-45. https://doi.org/10.1590/S0102-311X2006001300013
8. **Hufty M.** Gobernanza en salud pública: hacia un marco analítico. *Rev Salud Publica*. 2010;12(1s):39-61. https://revistas.unal.edu.co/index.php/revsaludpublica/article/view/33453
9. **Naranjo Giraldo G, Lopera Morales JE, Granada Vahos J.** Las políticas públicas territoriales como redes de política pública y gobernanza local: la experiencia de diseño y formulación de las políticas públicas sobre desplazamiento forzado en el departamento de Antioquia y la ciudad de Medellín. *Estudios Políticos.* 2009;(35):81-105. https://doi.org/10.17533/udea.espo.5157
10. **Rojas Rojas BG, Sánchez Dávila K.** Gobernabilidad local en épocas de pandemia en la región San Martin. *Ciencia Latina Revista Multidisciplinar.* 2021;5(4): 6211-6247. https://doi.org/10.37811/cl_rcm.v5i4.768
11. **Minoletti A, Sepulveda R, Gómez M, Toro O, Irarrazabal M, Díaz R, Hernández V, Chacón S.** Análisis de la gobernanza en la implementación del modelo comunitario de salud mental en Chile. *Revista Panamericana de Salud Pública*. 2018;(42). Disponible en: https://doi.org/10.26633/RPSP.2018.131
12. **Cabral-Bejarano MS, Nigenda G, Arredondo A, Conill E.** Rectoría y gobernanza: dimensiones estructurantes para la implementación de Políticas de Atención Primaria de Salud en el Paraguay, 2008-2017. *Ciênc Saúde Coletiva*. 2018;23(7):2229-2238. https://doi.org/10.1590/1413-81232018237.09242018
13. **Díaz-Castro L, Ramírez-Rojas MG, Cabello-Rangel H, Arredondo A, Báscolo EP.** Gobernanza en el sistema de salud ante la pandemia por Covid-19 en México. *Salud Pública México.* 2021;63(5):672-681. https://doi.org/10.21149/12956
14. **Arenas-Monreal L, Jasso-Victoria R, Villanueva-Borbolla MA, Bonilla P.** Experiencias de promoción de la salud y gobernanza en el ámbito local de México: retos y limitaciones. *Global Health Promotion.* 2012;19(1):83-89. https://doi.org/10.1177/1757975911429869
15. **Silva Morocho, MA.** Comités ciudadanos locales de salud: incidencia en el proceso de participación ciudadana del Cantón Palora, 2018 – 2021. [Especialización en Gestión y Gobernanza Territorial] Quito: Instituto de Altos Estudios Nacionales-IAEN, Universidad de posgrado del Estado; 2022. http://repositorio.iaen.edu.ec/handle/24000/6040
16. **Molina Guzmán A.** Funcionamiento y gobernanza del Sistema Nacional de Salud del Ecuador. *Íconos Revista de Ciencias Sociales*. 2019;(63):185-205. https://doi.org/10.17141/iconos.63.2019.3070
17. **Flores W, Gomez-Sánchez I.** La gobernanza en los Consejos Municipales de Desarrollo de Guatemala: Análisis de actores y relaciones de poder. *Salud Pública.* 2010;12(1s):138-150. https://revistas.unal.edu.co/index.php/revsaludpublica/article/view/33506
18. **Chanturidze T, Obermann K.** Governance in Health – The Need for Exchange and Evidence Comment on «Governance, Government, and the Search for New Provider Models». *Int J Health Policy Manag.* 2016;5(8):507-510. https://doi.org/10.15171/ijhpm.2016.60
19. **Osei Afriyie D, Hooley B, Mhalu G, Tediosi F, Mtenga SM.** Governance factors that affect the implementation of health financing reforms in Tanzania: an exploratory study of stakeholders' perspectives. *BMJ Glob Health.* 2021;6(8):e005964. https://doi.org/10.1136/bmjgh-2021-005964
20. **World Health Organization.** Health systems governance for universal health coverage action plan: Department of health systems governance and financing. [Internet] 2014 [cited 2025 Jun 22]. Available from: https://www.who.int/publications/i/item/WHO-HSS-HSF-2014.01

21. **Congreso de Colombia.** Ley Estatutaria 1751: por medio de la cual se regula el derecho fundamental a la salud y se dictan otras disposiciones. Consulta: junio 22, 2025. Disponible en: https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=60733
22. **Castro R.** En busca del significado: supuestos, alcances y limitaciones del análisis cualitativo En: I. Szasz y S. Lerner. Para comprender la subjetividad. Investigación cualitativa en salud reproductiva y sexualidad. México: COLMEX; 1996. p. 57-85.
23. **Guba E, Lincoln Y.** Paradigmas en competencia en la investigación cualitativa. En: C. Denman y J. Haro, (comps). Por los rincones Antología de métodos cualitativos en la investigación social. México: Colegio de Sonora; 2002. p. 113-145.
24. **Vives Varela T, Hamui Sutton L.** La codificación y categorización en la teoría fundamentada, un método para el análisis de los datos cualitativos. *Investigación En Educación Médica.* 2021;10(40):97-104. https://doi.org/10.22201/fm.20075057e.2021.40.21367
25. **Stake R.** Investigación con estudios de Caso. 6.a ed. Madrid: Ediciones Morata; 2020.
26. **Tamayo G.** Diseños muestrales en la investigación. *Semestre Económico*. 2000;4(7). https://revistas.udem.edu.co/index.php/economico/article/view/1410
27. **da Silva Barreto M, Simon BS, Marquete VF, de Souza RR, Girardon-Perlini NMO, Marcon SS.** Proceso de muestreo teórico en investigación de Teoría Fundamenta vertiente. *Rev Esc Enferm USP.* 2021;55:e20210212. https://doi.org/10.1590/1980-220X-REEUSP-2021-0212
28. **Gibbs G.** El análisis de datos cualitativos en investigación cualitativa. Madrid: Ediciones Morata; 2012.
29. **Álvarez Sousa A.** El constructivismo estructuralista: La teoría de las clases sociales de Pierre Bourdieu. *Rev Esp Investigaciones Sociológicas.* 1996;(75):145-72. https://doi.org/10.2307/40184032
30. **Castillo E, Vásquez M.** El rigor metodológico en la investigación cualitativa. *Colombia Médica*. 2003;34(3):164-7. https://doi.org/10.25100/cm.v34i.3.269
31. **Strauss A, Corbin J.** Bases de la investigación cualitativa. Técnicas y procedimientos para desarrollar la teoría fundamentada. 1.a ed. Medellín (Colombia): Universidad de Antioquia; 2002
32. **Flick U.** Introducción a la investigación cualitativa. Madrid: Ediciones Morata; 2018.
33. **García PD.** El método comparativo constante y sus potencialidades para el estudio de políticas educativas para la escuela secundaria en Latinoamérica. *Revista Latinoamericana de Estudios Comparados en Educación.* 2019;10(15):27-43. https://dialnet.unirioja.es/servlet/articulo?codigo=7075519
34. **Gutiérrez Builes FA.** Ruta para la atención de la persona con accidente cerebrovascular en una Institución Prestadora de Servicios de Salud en Colombia, bajo el enfoque de Atención en Salud Basada en el Valor (ASBV) [Tesis Doctorado en Salud Pública] Medellín. Universidad CES; 2025. https://hdl.handle.net/10946/9576
35. **Posada Zapata IC, Carmona Parra JA.** Cuando el dolor se vuelve político. [Tesis Doctorado en Ciencias Sociales] Manizales: Centro de Estudios Avanzados en Niñez y Juventud, Universidad de Manizales; 2022. https://ridum.umanizales.edu.co/handle/20.500.12746/6269
36. **Osorno Navarro MM.** Significados de las violencias sexuales ejercidas por paramilitares y su relación con las formas de afrontamiento y procesos de construcción de paz en las mujeres víctimas expuestas al conflicto armado interno en San Onofre, Sucre (1990-2005) [Tesis Doctorado en Ciencias Sociales, Niñez y Juventud] Medellín: Observatorio de la Salud Pública. Universidad CES; 2024. https://hdl.handle.net/10946/8454
37. **Rangel-Carrero DO, Posada-Zapata IC, Agudelo-Flórez P.** Archivos de entrevistas, diagramas y codificación de tesis Gobernanza del SGSSS. *Mendeley Data, V1*. 2025. https://doi.org/10.17632/rcjnv2w3m9.1

38. **Lopez-Mallama OM, Zapata Loboa YA, Banguero Mejía KY, Andrade Díaz KV, Salazar Villegas B.** Análisis de la Reforma del Sistema General de Seguridad Social en Salud 2022 – 2026: una Mirada desde el Plan Decenal de Salud Publica. *Ciencia Latina Revista Multidisciplinar.* 2024;8(1):1650-1664. https://doi.org/10.37811/cl_rcm.v8i1.9560

39. **Báscolo E, Debrott Sánchez D, Houghton N, Vance C.** Regulación y desempeño de los sistemas de salud: una revisión de los marcos de análisis. *Revista Panamericana de Salud Pública.* 2024;48. https://doi.org/10.26633/RPSP.2024.42

40. **Rothgang H, Cacace M, Grimmeisen S, Wendt C.** The changing role of the state in healthcare systems. *Eur Rev*. 2005;13(S1):187-212. https://doi.org/10.1017/S1062798705000256

41. **Vian T, Bicknell WJ.** Good governance and budget reform in Lesotho Public Hospitals: performance, root causes and reality. *Health Policy Plan.* 2014;9(6):673-84. https://doi.org/10.1093/heapol/czs121

42. **Cleary SM, Molyneux S, Gilson L.** Resources, attitudes and culture: an understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings. *BMC Health Serv Res.* 2013;13(320). https://doi.org/10.1186/1472-6963-13-320

43. **Pyone T, Smith H, Van den Broek N.** Frameworks to assess health systems governance: a systematic review. *Health Policy Plan.* 2017;32(5):710-22. https://doi.org/10.1093/heapol/czx007

44. **Abimbola S, Olanipekun T, Schaaf M, Negin J, Jan S, Martiniuk A.** Where there is no policy: governing the posting and transfer of primary health care workers in Nigeria. *Int J Health Plann Manage*. 2016;32(4):492-508. https://doi.org/10.1002/hpm.2356

45. **Brinkerhoff D, Bossert T.** Health governance: principal–agent linkages and health system strengthening. *Health Policy Plan.* 2013;29(6):685-93. https://doi.org/10.1093/heapol/czs132

46. **Siddiqi S, Masud T, Nishtar S, Peters D, Sabri B, Bile K, et al.** Framework for assessing governance of the health system in developing countries: Gateway to good governance. *Health Policy*. 2009;90(1):13-25. https://doi.org/10.1016/j.healthpol.2008.08.005

47. **Greer S, Wismar M, Figueras J.** Strengthening Health System Governance: Better policies, stronger performance. [Internet] 2016 [cited 2026 Jan 16]. Available from: https://eurohealthobservatory.who.int/docs/librariesprovider3/studies---external/strengthening-health-system-governance-better-policies-stronger-performance.pdf#page=42