



International  
Labour  
Organization

# ▶ Bridging Social Protection and Occupational Health Services in Colombia

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## Introduction

Human health is determined by physiological factors and by the conditions in which people are born, grow, live, work, play and age and the systems and forces that shape these – in other words, social, environmental, behavioural and political factors (Marmot 2001). At the individual level, the different determinants of health are not experienced in silo and therefore should ideally be tackled and addressed by employing a coordinated and holistic set of policies and institutional frameworks. Social protection and occupational safety and health systems both aim to address some of the social and environmental determinants of health for the working population and beyond, and in particular, occupational health services (OHS) and social protection schemes covering healthcare and employment injury and occupational diseases. They share a common public health objective of promoting good health, preventing (work-related) injuries and diseases, supporting access to health care without hardship, guaranteeing income security throughout sickness and injury and facilitating rehabilitation. In this respect, both policies directly support the achievement of SDG targets 1.3 and 8.8, respectively, and jointly contribute to the achievement of SDG 3 on health and wellbeing for all.

In support of coordinated and holistic approaches, a research project consisting of a scoping review and three country case studies was undertaken as part of the ILO-France Project “Universal Access to Social Protection and Health and Safety at Work” to generate an understanding of existing linkages and coordination mechanisms between national social protection systems and occupational health services, while also highlighting the current gaps in knowledge that need to be filled. This country case

study brings together the findings of the research in Colombia, with the aim of providing an overview of the existing coordination mechanisms between the national social protection system and the national occupational health services system, while also highlighting the current gaps that need to be addressed. By examining current practices and identifying areas for improvement, the report aims to facilitate the coordination of OHS services and the national social protection system, ultimately ensuring enhanced protection and well-being for all workers in the country.

## Social protection

Social protection is defined as a set of policies and programmes designed to reduce and prevent poverty, vulnerability and social exclusion throughout the life cycle (ILO 2024). The term encompasses a broad variety of policy instruments, including social insurance and social assistance, with most social protection systems adopting a combination of instruments to achieve their objectives. As outlined in the Social Protection Floors Recommendation 2012 (No. 202), it encompasses, at a minimum, access to healthcare without hardship, which includes maternity care, and income security throughout the life cycle (ILO 2019).

Several international social security standards enshrine the rights to health and social protection on a universal basis, and outline the minimum levels of protection that should be guaranteed by national systems and the minimum range of services to be covered. Income security during maternity and sickness are also guarantees outlined in Convention No. 102, contributing towards meeting health objectives and they are,

along with access to health care without financial hardship, the core components of social health protection (SHP) (ILO 2020). Access to healthcare without financial hardship is also a guarantee to which persons affected by work injury and occupational diseases are entitled under the international social security framework. Indeed, part VI of Convention No. 102 and the Employment Injury Benefits Convention, 1964 (No. 121) outline minimum standards for benefits in case of employment injury and occupational diseases. These are not prescriptive as regards to the institutional arrangements for the administration of these benefits, with the possibility of integrating the guarantees with others.

## Occupational health services

The ILO's normative framework on occupational safety and health (OSH) numbers over 40 instruments, including two fundamental Conventions. The Convention on the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187) calls for the promotion of continuous improvement of occupational safety and health through the development of a national OSH framework composed of a national OSH policy, a system and a programme. The Convention stipulates that a national OSH system – that is, the infrastructure through which OSH policies and programmes are implemented – itself should be composed of, among other components, a national tripartite advisory body on OSH, training, information and advisory services, occupational health services and provisions for collaboration with insurance or social security schemes covering occupational injuries and diseases.

Occupational health services are defined by the Occupational Health Services Conventions, 1985 (No. 161) as those services entrusted with essentially preventive functions, which are required to advise employers, workers and their representatives concerning the requisite means for establishing and maintaining safe and healthy working environments so as to promote optimal physical and mental health in relation to work and the adaptation of work to the capabilities of workers in consideration of their physical and mental health. Convention No. 161 and the Occupational Health Services Recommendation, 1985 (No. 171) call on States to progressively develop occupational health services (OHS) for all workers. Additionally, Convention No. 161 specifies the scope of functions of occupational health services as are adequate and appropriate to the occupational risks of the undertaking.

## Potential for synergies

In their respective objectives and complementary missions, there exist several opportunities for collaboration and coordination between occupational health services (OHS) and social protection, in particular, social health protection (SHP) and employment injury insurance (EII). Firstly, both systems have similar objectives with regard to the maintenance and restoration of health, whether at the workplace, in the case of OHS, and both within and beyond the workplace in the case of social protection systems.

The potential for such synergies is identified in relation to the responsibilities and functions outlined in the normative frameworks for social security and occupational health services. Convention No. 130 recognizes that the benefits covered by SHP include preventive care, wherein opportunities for institutional coordination with respect to the primarily preventive function of OHS might be identified. Moreover, Recommendation No. 171 provides for occupational health services to “engage in other health activities, including curative medical care for workers and their families, as authorized by the competent authority” depending on the national context and distance of the workplace to health facilities; while the list of medical benefits to be provided in case of employment injury or occupational disease under Convention No. 121 includes emergency and follow-up treatment at the place of work, where synergies can potentially be identified. Finally, the engagement of both OHS and employment injury insurance in vocational rehabilitation presents opportunities for coordination.

Further, recommendations on the governance and administration of OHS and social protection offer opportunities not just for collaboration but also for the deployment of greater synergies. International social security standards offer clear guidance on this point, outlining the primary responsibility of the state in guaranteeing the right to social protection. The standards are not prescriptive when it comes to the administrative and institutional arrangements for publicly-led schemes, as Article 7.2 of Convention No. 161 provides for a plurality of organisation modalities, including by social security institutions. This opens up the potential for synergies to be operationalized, or even the integration of some, if not all of the OHS functions.

It was against this background that the research endeavoured to identify the types of linkages that exist between OHS and social protection systems – and in particular, SHP and EII. Notably,

the research aimed to identify what the nature of linkages between OHS and social protection might be and those countries where they are reported. In this report, linkages are defined as direct and regularized relations between two or more institutions, that is, any policy, operative process or programme that formally or informally links social protection systems and occupational health services. An institution was considered to be any government agency, semi-private or private organization that is tasked with overseeing and administering specific functions of OHS or government-led social protection schemes.

## Methodology

This study is based on a desk review<sup>1</sup>, which was carried out to understand current policies, regulations, organisational arrangements and implementation of occupational health services, health insurance scheme, and the Occupational Accident and Disease Insurance Fund in Viet Nam, and the linkages between these. This desk review was complemented by Key Informant Interviews conducted in June 2024 with state actors to collect data which were not available in the public domain. Informants from the following institutions were interviewed:

- ▶ Secretaría de Salud Departamental de Bolívar
- ▶ Junta de Calificación de Invalidez, Ministerio del Trabajo
- ▶ Dirección de Riesgos Laborales, Ministerio del Trabajo
- ▶ Departamento del Trabajo del Departamento de Cesar
- ▶ Entidad Promotora de Salud (EPS) Salud Total
- ▶ Administrador de Riesgos Laborales Positiva
- ▶ Academia (Universidad de La Guajira)
- ▶ Asociación Nacional de Empresarios de Colombia (ANDI)
- ▶ Instituto Prestador de Salud (IPS) Atlántico

The case study begins with some background to the context in Colombia, including in relation to the OHS and social protection systems. The second section examines and analyses the linkages that exist between the systems and their potential

implications, as well as the existing opportunities for strengthened coordination between OHS and social protection, before concluding with some reflections on the implications of the findings.

## Country context

Colombia is an upper-middle-income country that has achieved strong progress in human capital development in the past decades. Nevertheless, some 55 per cent of employment in Colombia is informal (ILO, n.d.a.), where decent work deficits may prevail. Similarly, income inequality persists in the country, which in 2022 had the highest Gini index in South America (World Bank, n.d.). To promote social justice and economic inclusion, the Government of Colombia adopted the National Development Plan for 2022–2026, organized around five broad transformations wherein universal and adaptive social protection is highlighted as a core objective.

The Statutory Law on Health (Law 1751 of 2015) establishes the fundamental right to health, providing for access to timely, effective and quality health services for the preservation, improvement and promotion of health for all citizens. The Ten-Year Public Health Plan 2022–2031<sup>2</sup> outlines the broad objectives and strategies for guaranteeing this right, improving access to quality health services and promoting health and well-being amongst the population.

## Social protection system

Law 100 of 1993 brought about significant reforms to the social protection system in Colombia, seeing the creation of the Integral Social Security System<sup>3</sup>, composed of several subsystems. Here, the dual mandate of the Ministry of Health and Social Protection (MSPS)<sup>4</sup> over health and social protection offers a coherent legal and policy framework.

**The Social Protection System for Old-Age, Invalidation and Death of Common Origin<sup>5</sup>** was recently reformed through Law 2381 of 2024, composed of three pillars: the contributory pillar, the semi-contributory pillar, and the solidarity pillar. Affiliation to the contributory pillar is mandatory for all employees and self-employed persons and is financed by member contributions, while persons living below the poverty line or in

<sup>1</sup> See Bibliography

<sup>2</sup> Plan Decenal de Salud Pública

<sup>3</sup> Sistema de Seguridad Social Integral

<sup>4</sup> Ministerio de Salud y Protección Social

<sup>5</sup> Sistema de Protección Social Integral para la Vejez, Invalidez y Muerte de Origen Común

vulnerable situations are covered by the solidarity pillar with financing from the general budget.

**The General System of Occupational Risks (SGRL)**<sup>6</sup> aims to prevent and protect workers from work injuries and occupational diseases. Overall guidance is provided by, among others, the MSPS, the Ministry of Labour (MT)<sup>7</sup> and the National Council on Occupational Risks<sup>8</sup> and the scheme is largely implemented by Occupational Risk Administrators (ARL)<sup>9</sup>, which are private or public entities in charge of handling contributions and benefits and implementing prevention and promotion activities amongst affiliated workplaces. Employers are required to affiliate their workers, with free choice over which ARL to affiliate with in covering their workers, while coverage is voluntary for the self-employed, who can similarly choose their ARL. The services covered include medical care and rehabilitation, temporary disability benefits, disability pensions, survivors' pensions and funeral allowance. It is estimated that in 2023 just over half of the labour force was covered by the SGRL (CSS 2024; ILO, n.d.).

**Social assistance schemes**, including the Families in Action<sup>10</sup> programme, aim to provide financial support to low-income households to alleviate poverty and enhance social inclusion. These and other state subsidies are targeted through the Sisbén<sup>11</sup>, an information system that categorizes the population according to a range of socio-economic indicators. People in employment are typically excluded from access to social assistance.

The **General System of Social Security in Health (SGSSS)**<sup>12</sup> was also established by Law 100 of 1993 with the objective of achieving universal social health protection. Overseen by the MSPS, the scheme is administered through the Entidades Promotoras de Salud (EPS), or Health Promoting Entities, whose responsibilities are delegated by the state and include the management of the public health insurance, the affiliation of members, the collection of contributions and the reimbursement of health service providers (IPS)<sup>13</sup>. Coverage is mandatory for the entire population under three broad regimes: the contributory regime covering wage earners, the self-employed with earnings

above a specific threshold and retirees and which is financed by employers and worker contributions; the special regime covering the armed forces, the national police, the Colombian Oil Company, teachers and public universities; and the subsidized regime, which covers everybody else and is financed by government resources. Affiliates of all regimes access the same benefit package<sup>14</sup>, which includes prevention and promotion activities, emergency care, consultations, hospitalisation, specialist services, medicines, dentistry, mental health, rehabilitation and palliative care. The SGSSS also administers income support for temporary incapacity not resulting from work injuries or occupational diseases and maternity and paternity income benefits for persons affiliated under the contributory regime. In 2022, the system achieved a coverage of 99.1 per cent of the population (Ministerio de Salud y Protección Social de Colombia 2023b). Among the population with coverage, 51 per cent are covered under the subsidized regime, 45.7 per cent are covered by the contributory regime and 5.2 per cent are covered under the special regime (Ministerio de Salud y Protección Social de Colombia 2023a). The SGSSS is currently undergoing reform.

## Occupational health services

In Colombia, the organization of occupational health services is a multifaceted system aimed at preventing work-related injuries and diseases, ensuring worker safety and promoting health in the workplace. This system is governed by Decree Law 1295 of 1994 and Law 1562 of 2012 and complementary regulations, which establish a comprehensive occupational safety and health framework, as well as provide a strong basis for the occupational risk system (SG-SST)<sup>15</sup>. The National Plan for Occupational Safety and Health (PNSST)<sup>16</sup> for 2022–2031, as adopted through Resolution 3077 of 2022 by the MT, outlines the key priorities and strategies of the SGRL for the ten-year period. Various actors have responsibilities under the system.

The **MT** proposes and elaborates policies, standards, strategies, programmes and projects

<sup>6</sup> Sistema General de Riesgos Laborales

<sup>7</sup> Ministerio del Trabajo

<sup>8</sup> Consejo Nacional de Riesgos Laborales

<sup>9</sup> Administradoras de Riesgos Laborales

<sup>10</sup> Familias en Acción

<sup>11</sup> Sistema Nacional de Selección de Beneficiarios

<sup>12</sup> Sistema General de Seguridad Social en Salud

<sup>13</sup> Instituciones Prestadoras de Salud

<sup>14</sup> Plan de Beneficios en Salud. This is currently specified in Resolution 2366 of 29 December 2023 adopted by the Ministry of Health and Social Protection.

<sup>15</sup> Sistema de Gestión de la Seguridad y Salud en el Trabajo

<sup>16</sup> Plan Nacional de Seguridad y Salud en el Trabajo Plan Nacional de Seguridad y Salud en el Trabajo

and ensures compliance with labour regulations, including those related to occupational safety and health. It conducts inspections and investigations to ensure that employers fulfil their responsibilities towards workers. Together with the **MSPS**, they also play a critical role in formulating national policies and regulations related to occupational health. The MSPS itself is responsible for conducting research on occupational health trends, evaluating the effectiveness of existing programmes and promoting initiatives that enhance worker safety and health.

There also exist a **network of OSH committees and commissions** at national, sectional, sectoral and local levels, whose role includes the development of action plans and programmes within their jurisdictions based on the PNSST and establishing standards and promoting campaigns, programmes and events for dissemination, publication and training on occupational hazards in their jurisdiction besides other responsibilities (ILO 2022). The committees and commissions are tripartite with membership of workers, employers, the MSPS, the MoL, ARLs, academics and scientific organizations concerned with OSH.

As mentioned above, **ARLs** are responsible for managing occupational risk insurance in Colombia. ARLs also have a vital role in promoting workplace safety through preventive programmes and initiatives aimed at reducing occupational hazards. They work closely with employers to develop tailored safety plans and conduct regular inspections to ensure compliance with safety and health regulations. Part of member contributions to the ARLs also finance the activities of the **Occupational Risks Fund**<sup>17</sup>, overseen by the tripartite National Council of Occupational Risks, whose responsibilities include research and data generation and the implementation of broader campaigns on prevention and promotion.

Finally, **employers** are required for preventive measures to protect the safety and health of their employees, including by implementing the Safety and Health Management System in accordance with Decree 1072 of 2015 and Resolution 0312 of 2019. This includes conducting workplace risk assessments, establishing emergency response procedures, providing appropriate training and education on safety protocols and ensuring that workplaces comply with health standards, among other kindred responsibilities. Companies with

more than ten employees are also required to establish joint occupational health committees, while those employing fewer than ten employees must appoint an OSH officer.<sup>18</sup>

## Linkages between occupational health services and social protection

There are several linkages between the occupational health services and the social protection system in Colombia. The first is the integration of certain prevention functions of OHS with EII within the responsibilities of the ARLs, as alluded to above. This dual role results in several linkages between OHS and the social protection system. The second is the delivery of medical care in the event of work injuries and occupational diseases through the social health protection scheme, the costs of which are recovered from the EII for covered workers. The third is the exchange of information between schemes, which is closely tied to the first two linkages.

## Linkages relating to prevention and promotion activities

In relation to their responsibilities for prevention, article 11 of Law 1562 of 2012 specifies that 5 per cent of total contributions to the ARLs must finance the implementation of basic prevention and promotion activities, which include: education and prevention programmes; campaigns and actions to ensure that affiliated companies comply with rules and regulations on occupational safety and health and develop the requisite workplans under the occupational health programme; the provision of advisory services to affiliated companies on the same; training on the provision within affiliated companies of emergency care and training of joint occupational health committees in the monitoring of occupational health; promotion of healthy work and life styles; and the investigation of work accidents and occupational diseases presented by workers in their affiliated companies. In turn, up to 3 per cent of contributions must be allocated to financing the work of the Occupational Risks Fund, which is in charge<sup>19</sup> of conducting research, campaigns, education and investigation of occupational accidents and diseases and for establishing an Occupational Risks Information System<sup>20</sup>. The Fund can also contribute financing

<sup>17</sup> Fondo de Riesgos Laborales

<sup>18</sup> Vigía

<sup>19</sup> According to article 22 of Law 776 of 2002 as amended by article 43 of Law 1438 of 2011.

<sup>20</sup> Sistema de Información de Riesgos Laborales

to the elaboration of prevention and promotion activities implemented within the primary health care system. Of the 92 per cent of remaining contributions, the ARLs are also required to dedicate a further 10 per cent to the development of programmes to cover the following: the prevention and control of occupational risks and comprehensive rehabilitation in affiliated companies; support for member companies in permanently monitoring working and health conditions and implementing effective risk control; implementation of activities to achieve comprehensive rehabilitation, readaptation, reinsertion and labour reallocation, including workplace adjustments; and conducting activities to reduce exposure to occupational risks.

There are important linkages that are, or could be, achieved through the dual role played by the ARLs, as well as through the prevention and promotion activities implemented by the Occupational Risks Fund.

Firstly, the dual role played by the ARLs in the compensation and prevention of work injuries and occupational accidents offers an important opportunity for synergies, particularly in the data generated from the former to inform the design and targeting of the latter. This can contribute towards improving the targeting of prevention activities as well as the tailoring of the activities' content, thus promoting not just their overall effectiveness but also their efficiency; indeed, it is reported that certain ARLs do design tailored initiatives for specific companies or sectors among their affiliates based on claim data and statistics on occupational accidents and diseases.

More indirectly, the information collected under the social protection system also helps to inform decisions about the types of prevention and promotion activities to be implemented at the sub-national level. The Integrated Social Protection Information System (SISPRO)<sup>21</sup> of the MSPS is comprised of databases and information systems on supply and demand for health services, quality of services, financing and social promotion. The MSPS also has information on numbers of occupational accidents and diseases and deaths. This information represents a fundamental input for decisions on prevention and promotion campaigns to be implemented, as well as an input for analysis by the network of committees, including the National Council of Occupational Risks, which defines promotion and prevention activities within the framework of the actions of the Occupational Risks Fund.

Secondly, given the roles of both ARLs and EPS in implementing prevention and promotion activities, albeit with a different focus, there may exist opportunities for joint initiatives. However, there is little reported coordination between the prevention and promotion on occupational health on the one hand and wider public health promotion activities on the other.

This may in part be due to the limited coverage of the ARLs' prevention and promotion activities, which are implemented among affiliated companies, while the EPSs' prevention and promotion activities are not specifically targeted at the workplace level. But the Occupational Risks Fund has the authority to implement prevention and promotion activities with the potential to reach workers in the informal economy and therefore to coordinate with health sector institutions in this regard. This entity is financed by contributions from workers and employers, who therefore partly subsidize prevention activities for workers in informal employment.

### Linkages in the provision of medical care for work injuries or occupational diseases

The ARLs are also responsible for compensating affiliated workers affected by work injuries or occupational diseases. In such cases, affiliated workers are entitled to income support and medical services, which include medical, surgical, dental and hospital care; medicine; appliances; rehabilitation; and transportation.

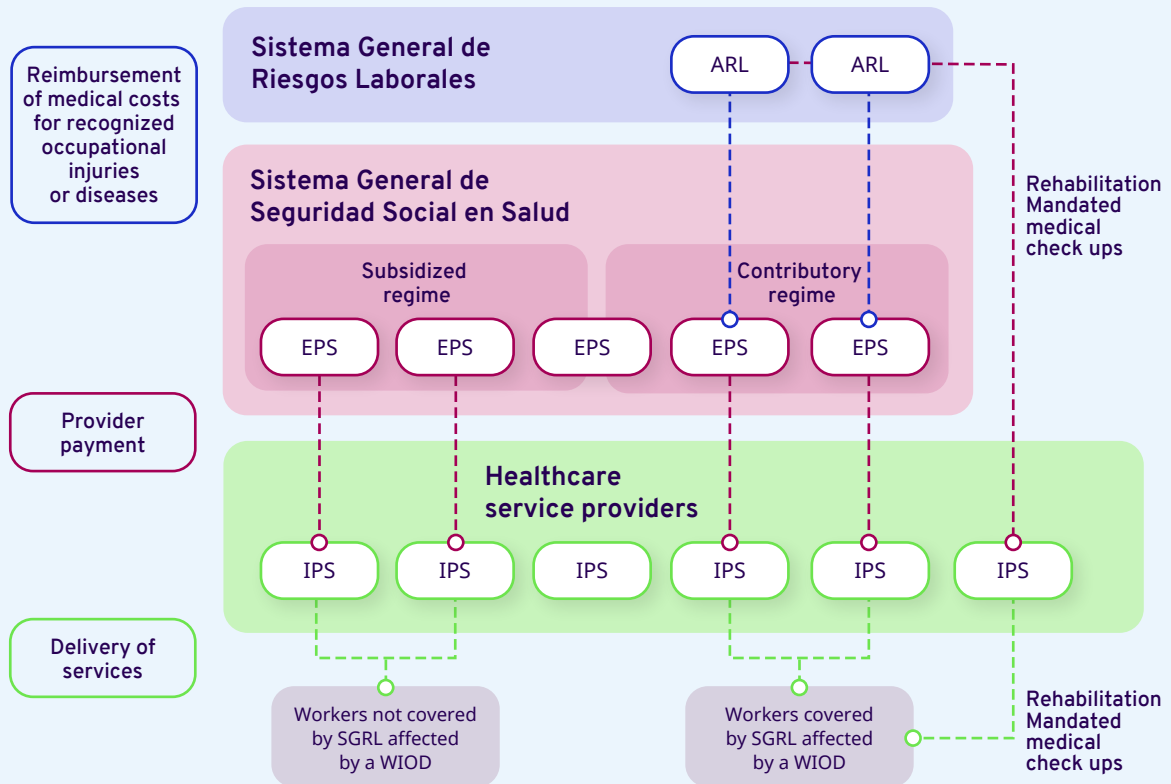
A linkage exists between the ARLs and the EPS. According to Law 100 of 1993, with additional details elaborated in Decree Law 1295 of 1994, the provision of health services in the case of occupational injuries and illnesses is meant to be carried out through the EPS networks and the costs of the services are recovered from the ARLs once the origin of the injury or illness has been proven to be occupational. In the case of rehabilitation services, the ARLs can organize or contract service providers directly for the delivery of services to affiliates with their own resources. In practice, the insurance companies have established their own networks of service providers for services for conditions of both occupational or common origin (or have directly created IPS), and affiliated workers affected by a work-related injury or occupational disease can choose where to access services on the basis of geographical proximity. The disability

<sup>21</sup> Sistema Integrado de Información de la Protección Social

income benefits provided to workers affiliated to the contributory scheme of the SGSSS are assumed by the ARLs if the disability is identified as being the result of a work injury or occupational disease. Income support and services covered up to three years before the occupational origin of the disease or injury is confirmed are recovered from the ARLs (Law 1562 of 2012). EPSs and ARLs therefore communicate on the delivery of services

provided to workers affiliated to the latter. Given this linkage, employers must report work injuries or occupational disease both to EPSs and ARLs (Decree Law 1295 of 1994). Thus, all workers are able to access health services regardless of the origin of the event; the costs are borne by the SGSSS if workers are not affiliated with the SGRL and or if the injury or disease is not recognized as occupational in origin.

► Figure 1: Illustration of the arrangements for the delivery and coverage of medical services to workers affected by WIOD according to Law 100 of 1993 and Decree-Law 1295 of 1994



These institutional arrangements have a range of implications.

### Implications

First, the SGSSS service delivery network allows for greater health care **coverage**, both for injuries and health conditions of common origin and those resulting from work, given the almost universal coverage of the SGSSS (ILO Forthcoming a). If this coverage were administered solely by the SGRL, access to care would be more limited as approximately half of the workforce would be covered. Second, the fact that medical care covered by the ARLs is accessed through the EPSs'

network of service providers may also represent a mechanism for expanding the geographical coverage of services, building as this approach does on existing infrastructures established under the social health protection system.

On the other hand, only workers affiliated with the ARLs are entitled to access employment injury cash benefits in the event of a work injury or an occupational disease, which leaves over half the labour force uncovered. Financial protection against the costs of accessing healthcare services and income security are highly complementary and mutually reinforcing, with the effectiveness of the one enhanced by access to the other. It is important to ensure that their complementary

objectives are achieved, including through the expansion of coverage of the SGRL.

The situation also has **financial implications**, whereby the costs of medical care for work injuries and occupational diseases for over half of the workforce are covered by the SGSSS. This is compounded by the fact that workers in the informal economy are at higher risk of work injury or occupational disease owing to the lower level of compliance with occupational safety and health laws and regulations, the lack of coverage by the prevention and promotion activities implemented by the ARLs and the limited reach of those implemented by the Occupational Risk Fund. Even among workers affiliated with the SGRL, there is evidence to suggest that not all work injuries or occupational diseases are reported as such (ILO 2022), the costs of which would therefore also be covered by the SGSSS. This is important as several EPSs are facing a deteriorating financial situation, with over 13 having already ceased operating owing to insolvency (Albarracín Restrepo 2023). The exact scale of the financial burden is not currently known, as the non-contributory regime of the SGSSS did not monitor the origin of injuries or diseases of covered services, although this is being redressed with the Ten-Year Public Health Plan 2022–2031, calling for the establishment of epidemiological surveillance of health events related to occupations covered by the subsidized regime, which could at least partially fill important knowledge gaps. The financial implications potentially provide another a strong incentive for the coverage of the SGRL to be expanded but also potentially for alternative procedures to be identified for compensating the SGSSS similar to those that exist in France, for example.

The current arrangements also create incentives for cost shifting, which in turn is noted to undermine incentives for coordinated action. This also has implications for affected workers, who face delays in receiving the income support to which they may be entitled under the SGRL, the replacement rate of which is higher than under the SGSSS.

The provision of medical care in the event of work injuries and occupational diseases through EPSs could also be considered to contribute towards promoting uniformity in the **quality** of the care provided for events of both common and occupational origin. In practice, however, it was reported that there are differences in the speed at which EPSs and ARLs approve the provision of services that require pre-approvals, including surgery or medicines, resulting in differences

between the two systems in terms of the waiting times to access certain non-emergency services.

The provision of medical care in the event of occupational and common injuries and diseases through EPS also holds potential to facilitating the provision of integrated care in which occupational and general medicine are delivered in tandem, with an exchange of information on patient medical histories. This potential is, however, undermined by two factors. The first is the creation amongst some ARLs of their own network of service providers, as well as the separate administration of rehabilitation services, which may ultimately also compromise the continuity of care provided unless adequate coordination is in place. The MSPS and the MT are, however, in the process of discussing potential reforms that would contribute to a more integrated approach towards rehabilitation across the two systems. Secondly, records from prescribed occupational health examinations conducted by employers are not reported under any monitoring system and are hence not integrated into individuals' medical histories.

Finally, the current arrangements have several implications from an **administrative perspective**, particularly for the ARLs. Indeed, the legislative provisions calling for medical services to be provided through the EPSs and then reimbursed by the ARLs can provide important gains in terms of efficiency. Providing care through the existing infrastructures under the SGSSS avoids ARLs having to establish their own network of service providers, removing the need to contract with healthcare facilities, negotiate fees and process and pay claims arising from these, which administratively are burdensome processes. In practice, however, several ARLs do contract directly with IPSs, or establish their own. While this is provided for in the legislation, it does nevertheless undermine the achievement of such efficiency gains.



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### Exchange of information between occupational health services and social protection for occupational health surveillance

The interviews highlighted the absence of a comprehensive **monitoring** framework not just for occupational risks but also for work injuries and occupational diseases. There is therefore no comprehensive and consolidated data available which might inform the design and implementation of effective prevention and promotion activities that reach all workers at national and local levels.

Indeed, while there are several separate databases in which different data points are shared, they are not exhaustive. First, the Individual Health Service Provision Records<sup>22</sup> of the MSPS holds the data required to monitor the health service provision within the SGSSS. This does not, however, include information on occupational health checks, which could be useful for effective monitoring of changes in health status resulting from

exposure to occupational hazards. Likewise, the subsidized regime does not monitor the common or occupational origin of an injury or illness, thus also yielding a partial picture. This also applies to the information in the SISPRO mentioned above. The country's regulations further provide for the establishment of an Occupational Risks Information System<sup>23</sup> with funds from the Occupational Risks Fund, to be fed by information on the benefits provided by the ARLs and health conditions presented by their affiliates<sup>24</sup>. The monitoring picture is therefore fragmented and incomplete, including owing to the absence of data on workers in the informal economy, who represent half of the workforce, and the under-reporting of occupational accidents and diseases (ILO 2022).

However, important initiatives are underway to overcome the above. These include the creation of unified information systems. Moreover, as mentioned above, the Ten-Year Public Health Plan foresees the characterization of different prioritized population groups for

<sup>22</sup> Registros Individuales de Prestación de Servicios (RIPS)

<sup>23</sup> Sistema de Información de los Riesgos Laborales

<sup>24</sup> This information can currently be consulted through different sources such as FASECOLDA and the MSPS.

use in generating a comprehensive mapping of the social determinants of health among the population. While the data collection process is ongoing (the plan having only been adopted in 2022), this initiative will include workers in the informal economy and will use an extensive range of indicators, including occupations, health profile, health conditions and occupational risks, among others (Ministerio de Salud y Protección Social de Colombia 2022, 2022–31). This survey, which is administered by the Departmental Health Secretariats of the MSPS, requires the active participation of EPSs, IPSs and ARLs and will contribute to efforts to establish a comprehensive mapping of occupational risks, with the potential to inform the design of integrated approaches towards addressing the social determinants of health.

## Conclusion

There are important linkages that exist between OHS, EII and SHP in Colombia. Firstly, prevention and compensation of work injuries and occupational diseases are integrated functions administered by the same institution. Secondly, medical care for work injuries and occupational diseases are meant to be accessed through the network of service providers of the social health protection system. ARLs cover the costs of these contingencies for affiliated workers, while the SGSSS covers costs for workers not affiliated to the ARL and workers in the formal economy whose work-related injury or disease has not officially been recognized. Thirdly, data generated through the social protection system (including ARLs) informs the design and implementation of occupational safety and health prevention and promotion activities. Finally, initiatives are underway to generate comprehensive data on social and environmental determinants of health, including occupational risks and hazards, with the objective of informing the design of integrated, intersectoral action to promote health and well-being, both in and outside of work.

However, these linkages do not necessarily translate into effective and systematic coordination between OHS and social protection. This, it is argued, is the result of the institutional separation between the SGRL, the SGSSS and other social protection schemes, each with independent objectives to achieve. Further still, the limited scope of coverage of the SGRL, both in terms of the population and geography, reduces opportunities for coordination. The lack of comprehensive data on the occupational risks faced by workers in the informal economy is considered a further

challenge to the design and implementation of joint activities. Finally, it may also be pertinent to investigate how the delegation of SHP, OHS, and EII administration to mostly private institutions (both in the case of EPS or ARLs) might affect coordination and synergies.

Nevertheless, opportunities exist for synergies and improvements. For example, it was reported that there is limited coordination in prevention and promotion activities, which are largely implemented in isolation by the MSPS and SHP schemes on the one hand and OHS on the other. Collaboration between these holds the potential to expand the reach of occupational prevention and promotion activities, including the potential to pool resources and piggyback on existing initiatives and infrastructures. Incentives should also be established to promote coordination leading to improved reporting of work injuries and occupational diseases and enhancing the processes for their recognition, both of which continue to be a challenge.

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