Colombia: a primary health care case study in the context of the COVID-19 pandemic

Jaime Rodríguez Moreno
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Executive summary

Since 2015, Colombia has changed the operating model of its health system to focus on the more structural implementation of its primary health care (PHC) strategy. This strategy, which will be operationalized through the MAITE model (Comprehensive Territorial Care Model) (Ministry of Health and Social Protection, 2019a), establishes activities and responsibilities for the different agents within the system, using a model based on the health needs of the population.

The implementation of this model, which was due to start in 2020 (Ministry of Health and Social Protection, 2020a), was delayed by the COVID-19 pandemic. Its implementation was intended to make it essential to improve citizens’ access to health services and to improve promotion and prevention activities. The pandemic has generated lessons to inform effective implementation of this model, thus facilitating the continuity and sustainability of learning, improving the efficiency of the health system and producing better health results for the population.

Colombia strengthened its hospital capacity during the COVID-19 pandemic, increasing the availability of hospital infrastructure and the provision of services through telehealth and home care (PAHO, 2020). It also strengthened information management to enhance public health surveillance, decision-making based on information in real time and service networks to achieve better results. Key lessons can inform the implementation of the MAITE model, building from an understanding of the different approaches of each of the country’s regions.

The PHC approach affirms the participation of citizens within the decision-making process, in such a way that PHC provision is transformed from care that is based on the preferences of institutions to care that centres on the health needs of the user, the family and the community. However, the COVID-19 pandemic has shown that the community and community organizations, as well as public and private health institutions, face challenges in collaborating effectively to enable community participation. There is, therefore, an opportunity for these organizations to work together, articulating and coordinating activities to improve their capacity to enhance trust in, and the legitimacy of, the institutions of the health sector (Restrepo Zea & Zapata Cortés, 2021).

Similarly, the institutions of the health sector and other sectors, including the political sphere, could promote spaces that allow citizens and different actors to understand that health is a result of multiple determinants. Multisectoral collaboration is essential to improve population health and well-being. This would transform the concept of health, confirming that it involves not only hospital care, but also social, economic, environmental and cultural elements, among others. It would, in turn, strengthen the self-care capacities of the population, leading to better health outcomes.
This case study examines PHC in Colombia in the COVID-19 pandemic context between March 2020 and July 2021. The case study sets out the efforts and actions developed by Colombia’s national and territorial governments and the private sector to address the pandemic, and considers the strengths and weaknesses of this response. It draws on evidence derived from academic studies, official reports and the perspective of citizens, health professionals and decision-makers at local and national levels.
Introduction

The health system in Colombia is based on the insurance of the population through benefit plan management companies (EPS). They receive an annual fee called the capitation payment unit (UPC) from the national government to cover a list of health services (including individual health promotion and disease prevention activities), procedures, medicines and health technologies under a health benefits plan (PBS).

More than 98% of Colombia’s people are affiliated with the health system. In other words, they have coverage for the provision of health services by the State. Around 47.9% are in the subsidized regime (i.e., they do not contribute financially to the health system), and 48.1% are in the contributory regime (i.e., employees and their beneficiaries, with the employee contributing financially to the health system), with 2.5% covered by special systems (such as members of the armed forces and others eligible for special benefits) (Ministry of Health and Social Protection, 2019b). Each EPS must contract a network of health institutions (hospitals, diagnostic support centres and pharmacies) to guarantee the provision of health services to the population under their care.

During the COVID-19 pandemic, the national government issued emergency decrees to facilitate decision-making in each of the country’s territories. The initial response to the emergency was the total closure of the country. Movement restrictions were introduced to contain the spread of the virus. Each government department and district established response measures based on the number of beds available in each intensive care unit (ICU) or the number of COVID-19 cases by regions or towns.
## Table 1. Colombia’s demographic and population health indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Results</th>
<th>Source</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>50.3 million</td>
<td>DANE (2018)</td>
<td>2020</td>
</tr>
<tr>
<td>Urban population</td>
<td>76.1%</td>
<td>DANE (2018)</td>
<td>2016</td>
</tr>
<tr>
<td>Rural population</td>
<td>23.9%</td>
<td>DANE (2018)</td>
<td>2016</td>
</tr>
<tr>
<td>Migrant population</td>
<td>1.75 million</td>
<td>R4V (2021)</td>
<td>2020</td>
</tr>
<tr>
<td>Female proportion</td>
<td>51.1%</td>
<td>DANE (2018)</td>
<td>2020</td>
</tr>
<tr>
<td>Male proportion</td>
<td>48.9%</td>
<td>DANE (2018)</td>
<td>2020</td>
</tr>
<tr>
<td>Population density (people/sq.km)</td>
<td>44</td>
<td>Ministry of Health and Social Protection (2019b)</td>
<td>2020</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>77.1 years</td>
<td></td>
<td>2018</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>11.3/1000 live births</td>
<td></td>
<td>2019</td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>14.1/1000 live births</td>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>64.9 /100 000 women of reproductive age</td>
<td></td>
<td>2020</td>
</tr>
<tr>
<td>Immunization coverage under 1 year</td>
<td>Up to 90%</td>
<td>Ministry of Health and Social Protection (2019b)</td>
<td>2020</td>
</tr>
<tr>
<td>Skilled birth attendance (% of pregnant women)</td>
<td>98.60%</td>
<td></td>
<td>2020</td>
</tr>
<tr>
<td>Four recommended antenatal care (ANC) visits</td>
<td>92.5%</td>
<td></td>
<td>2015</td>
</tr>
<tr>
<td>Illiteracy</td>
<td>12.93%</td>
<td></td>
<td>2018</td>
</tr>
<tr>
<td>Income or wealth inequality (Gini coefficient)</td>
<td>51.3</td>
<td>World Bank (2019)</td>
<td>2019</td>
</tr>
<tr>
<td>PHC expenditure as % of total health expenditure</td>
<td>59%</td>
<td>Ministry of Health and Social Protection (2019c)</td>
<td>2019</td>
</tr>
<tr>
<td>% total public sector expenditure on PHC</td>
<td>100%</td>
<td>Ministry of Health and Social Protection (2019c)</td>
<td>2019</td>
</tr>
<tr>
<td>Total health expenditure as proportion of gross domestic product (GDP)</td>
<td>7.20%</td>
<td></td>
<td>2019</td>
</tr>
<tr>
<td>Total expenditure on health per capita</td>
<td>US$ 9620</td>
<td>OECD (2021)</td>
<td>2019</td>
</tr>
<tr>
<td>Out-of-pocket payments as proportion of total expenditure on health</td>
<td>14.90%</td>
<td></td>
<td>2020</td>
</tr>
</tbody>
</table>

Source: Authors’ elaboration, with data from the designated entities.
Population health activities (collectively and in the community) are developed by health teams working across departments, districts and municipalities through the public hospitals. These activities include community education, epidemiological monitoring of diseases, massive prevention campaigns (such as those related to vector-borne diseases), and individual health services according to identified risk.

Colombia began a process to strengthen its health system in 2015, aiming for a greater emphasis on PHC with a community approach. This is based on territorial characteristics (urban areas, large cities, rural areas and municipalities where populations are widely dispersed). It aims to improve the strength and efficiency of health institutions that serve as a gateway to the health system: institutions of PHC (health centres), with a focus on health promotion and the prevention and management of primary health risks through interventions that also address the social determinants of health (Ministry of Health and Social Protection, 2016).

In 2019, this evolving process introduced a change to the MAITE model (Comprehensive Territorial Care Model) that aims to create a health system that is based on regional characteristics and responds to the diversity of territories and their specific social, economic, geographic and cultural conditions (Ministry of Health and Social Protection, 2019a).

The MAITE model has two strategies (PHC and health risk management); two approaches (health care and differential approach); and seven lines of action (health insurance, public health, health service provision, human talent in health, financing, differential approaches and intersectionality). Through this model, governments of the territories will ensure the health and well-being of their citizens, based on the characteristics of each of the departments and districts (Ministry of Health and Social Protection, 2019a).

The MAITE Model implementation, which was being led by each of the departments and districts, was halted in 2020, following the first confirmed case of COVID-19 infection in the country in March of that year. The national government had to take urgent action to delay the spread of the virus and prevent the collapse of the country’s hospital network (Ministry of Health and Social Protection, 2020a).

The Colombian health system started its organizational, operational and technical preparation for the COVID-19 pandemic in January 2020. National committees were activated, comprised of multidisciplinary teams of experts in epidemiology and public health, and decision-makers and other representatives from the scientific sector, with these committees focused on preparing for initial cases. However, when the first confirmed case was recorded in Colombia in March 2020, there was no capacity to conduct tests for COVID-19 and there had been no hospital expansion in any city (PAHO, 2020).
As of July 2021, around 4 million confirmed cases of COVID-19 had been recorded in Colombia and more than 90,000 deaths. The third wave of the pandemic in Spring 2021 was the most severe, both in terms of the number of confirmed cases and mortality. This wave had the greatest impact on the young adult population, with longer stays of patients in ICUs and a greater risk of collapse of the health care system (Instituto Nacional de Salud, 2021a).

**Methodology**

To examine PHC in Colombia in the COVID-19 pandemic context between March 2020 and July 2021, a literature review and consultations with key stakeholders were conducted. The literature review examined reports by the Ministry of Health and Social Protection and other public bodies for the national population or for international organizations. Quantitative data were obtained from official public sources.

Stakeholder consultations were undertaken with key actors at the national and territorial levels, and from different parts of the health sector. They included representatives from different organizations that intervene in the health sector and that are part of diverse elements addressed within Colombia’s PHC strategies. Participants were selected to reflect the structure of the health system, as well as elements of the PHC process. Actors were also sought from each of the types of entities to obtain expert, policymaker and service insights for the case study (Table 2).

**Table 2. Identification of stakeholders**

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Main constituency represented</th>
<th>Level of health system at which active</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory entity providing health services</td>
<td>Institutions providing health services</td>
<td>Health service provision</td>
</tr>
<tr>
<td>Ambulatory and hospital entities providing health services</td>
<td>Institutions providing health services</td>
<td>Health service provision</td>
</tr>
<tr>
<td>Territorial health directorate</td>
<td>Local government</td>
<td>Local government</td>
</tr>
<tr>
<td>Health-promoting companies</td>
<td>Insurance</td>
<td>Institutions</td>
</tr>
<tr>
<td>Promotion and prevention management representative</td>
<td>National Government</td>
<td>Central Government</td>
</tr>
<tr>
<td>Public University Health Programme Leader</td>
<td>Academia</td>
<td>Health education</td>
</tr>
</tbody>
</table>

Source: the authors.
How primary care and essential public health functions are responding to COVID-19

Colombia began to prepare for the COVID-19 pandemic before the first case was confirmed. The government established control and monitoring measures for international travellers from countries with a high number of cases and the closure of borders (air, land and sea) 10 days after the first case was diagnosed in the country. These activities, combined with the general quarantine measures across the country, marked the start of comprehensive health management during the COVID-19 pandemic.

The provision of health services during the pandemic focused on two essential aspects. First: strengthening outpatient and hospital components for the care of patients with COVID-19. And second: managing the continuity of health services for pathologies and health conditions not related to the pandemic. These two aspects were affected by the different stages of the pandemic.

Scaling up and managing critical emergency services (emergency rooms, hospital beds and ICU beds)

The first actions in response to COVID-19 focused on strengthening the capacity to respond to people with symptoms or a full diagnosis of COVID-19 infection. As the result of an action plan that involved the national government, territorial governments and the private sector, more than 150 authorized centres were created to conduct tests in every department across the country (Ministry of Health and Social Protection, 2021b).

The second step was the expansion of hospital capacity. Strategies carried out at the institutional level by public and private hospitals increased, for example, home care for patients with mild symptoms and the use of telehealth tools (mobile apps and the use of services by videocall or by telephone) for the delivery of PHC services in particular (OCHA, 2020).

The number of hospital beds was expanded to receive a greater number of patients, and to separate or differentiate emergency services for symptomatic COVID-19 patients and those who had complications caused by other acute diseases. The number of ICU beds was also increased from 5346 beds to 12 620 beds (Ministry of Health and Social Protection, 2021b). However, the increase in ICU beds also demanded an increase in the capacity of health care workers, in supply management and in support services. In response, the national government initiated more flexible arrangements for the imports of essential supplies such as anesthetic gases, muscle relaxants and supplies of personal protection equipment (PPE) for health care workers.

The preparation of health care workers at all levels (including those working in ambulatory and hospital facilities) focused on two essential elements. The
first element was the technical preparation of health workers across the
different services to enable them to detect, diagnose and treat patients with
COVID-19 according to the degree of severity of the disease, and to increase
the availability of health professionals. It was necessary, therefore, to be more
flexible about the requirements for professionals for work in critical services,
to support health professionals with specialized training and close noncritical
services at times of high demand to maintain the availability of essential care
(Hernández Rincón et al., 2021).

The strengthening of information systems for decision-making was the second
key element. This involved the development of CoronApp, an app that citizens
could use to obtain information about COVID-19, its characteristics and what to
do if someone has symptoms. CoronApp also allowed people to conduct a self-
assessment, report symptoms and record any contacts with possible positive
cases. In addition, the app’s georeferencing system enabled national health
entities to monitor the behaviour of population groups, indicating sources of
contagion or outbreaks in specific areas and making it possible to implement
public health measures focused on specific population groups.

In addition, a digital tool was created at the national level to inform
decision-making and publicize the situation of the disease in Colombia:
https://covid19.minsalud.gov.co/. This tool provided information updated
daily on the number of confirmed cases, the number of tests carried out, the
degree of severity of the disease and the distribution of patients in each of the
municipalities. It also compiled regulations for the response to the pandemic
and reports on the donations received by Colombia from the private sector,
multilateral organizations and the governments of other countries (Ministry of
Health and Social Protection, 2021b).

Through its National Institute of Health, Colombia has a robust epidemiological
surveillance system to inform health decision-making. This includes information
across all levels, from the primary data generating units (all health service
providers at the national level, including laboratories) to the central government
level. This system had been in operation for more than 20 years and at the time
of data collection operated through a web application. The application includes
each of the mandatory reporting pathologies (such as some communicable
diseases and other health issues of high interest to the country such as orphan
diseases, which affect a relatively small number of people and for which no drug
therapies have been developed) and other emerging issues such as COVID-19.
To ensure permanent monitoring, Colombia published daily reports of COVID-19
cases, severity, exact location, diagnostic confirmation and all demographic and
epidemiological data (age, race, sex and others such as location, insurance and
socioeconomic features), which informed the necessary actions at the territorial
or national level (Instituto Nacional de Salud, 2021b).
Continuing essential services

The provision of health services to the general population in terms of health promotion, disease prevention, outpatient care for general pathologies and care for chronic diseases (noncommunicable diseases or NCDs) during the pandemic was shaped by the number of active cases of COVID-19 at a given point. Colombia had experienced three periods of the COVID-19 pandemic by July 2021.

As noted earlier, the first period was characterized by the preparation of services, involving a partial closure of health promotion and prevention activities, especially in services such as the early detection of cervical cancer, vaccination activities and counselling for family planning. There was also partial closure of unscheduled activities such as non-urgent outpatient surgeries and the care for patients needing specialized services or treatments. During this period, there was continuity in care services for outpatients with NCDs such as hypertension and diabetes; however, the care of chronic patients with conditions such as cancer was partially affected (World Bank Group, 2020).

The second period related to the three peaks of recorded cases of COVID-19. Outpatient services were closed during each of these peaks, but, in contrast to the preparation period, telehealth and home care services for non-urgent health conditions were strengthened and there was better preparation for the care of patients with complex and chronic diseases (Ministry of Health and Social Protection (2021a). Although activities of community-based health managers are part of a national strategy, in some municipalities, this modality is used to address special situations such as malaria control, support and nutritional care. These services were suspended when there were high numbers of COVID-19 cases.

The third period was characterized by fewer COVID-19 cases, enabling normal provision of care for patients across all health services, including promotion and prevention.

The impact of the COVID-19 pandemic on maternal care services varied across the country. In municipalities with fewer inhabitants (where COVID-19 had less impact) services remained continuous, with little or no pandemic-related interruptions. In large cities, however, maternal care services decreased, particularly during the first four months of the pandemic. They were later normalized through the continuity of consultations within facilities and through home services and telehealth. Follow-up to postnatal care was reduced throughout the pandemic and especially at times of the greatest number of cases.

An important difference between urban and rural areas was geographic access to health services, as well as access to telephone and internet services. Such access is lower in rural areas, which hinders telehealth services. There are also important cultural differences, given that personal health care for the populations in rural areas generates more trust and credibility, resulting in greater utilization of health services (OCHA, 2020).
Strategies to enable continuity of care were accompanied by activities for individual and collective epidemiological monitoring of diagnosed cases of COVID-19 to provide additional tracking for the CoronApp mobile application. Multidisciplinary health teams under the leadership of the National Institute of Health were deployed in each of Colombia’s departments to implement case analysis, patient monitoring and patient tracking under a strategy called PRASS (Tests, Tracking and Sustainable Selective Isolation).

The PRASS strategy captured the characteristics of the patient, their contacts and established the actions to be taken, such as isolation to avoid contacts or outbreaks in each territory. This strategy determined activities by different institutions, including public and private health care providers at all levels, epidemiological teams from local authorities and insurance organizations (Ministry of Health and Social Protection, 2020b).

The health sector response to the pandemic included a review of the impact of the pandemic on the financing of health services, given that the use of health services increased (number of patients, frequency of use and type of services). The national government had to find additional resources to pay for health services, including the expansion of hospital capacity and of ICU beds for COVID-19 patients, and to guarantee the functioning of the beds at times of low demand for services during the pandemic (OCHA, 2020).

Finally, the protection of health care workers was a priority during the pandemic. This protection included the regulation of protocols for the use of PPE by workers, as well as the delivery of PPE by hospitals, the territorial government health entities, the national government and the administrators of occupational risks. With support from the governments of other countries, the national government managed to provide this equipment to avoid shortages of PPE elements that were not manufactured in Colombia, or those that were made with imported raw material (Ministry of Labor & Ministry of Health and Social Protection, 2020).

How multisectoral policy and action are responding to COVID-19

Colombia’s social determinants of health approach is implemented through programmes developed by the national government that span not only the health sector, but also other sectors that have an influence on these basic determinants. The approach is part of the public policies derived from the Decennial Public Health Plan (2012) and it has eight dimensions (see Fig. 1). This intersectoral approach, based on a social and citizen mandate and the capacities of the country’s territories, is aligned with the objectives of sustainable development (Ministry of Health and Social Protection, 2012).

The PHC strategy is part of the structure of the overall health system. It includes the provision of individual health services (prevention activities, early detection or activities to solve problems related to diseases) and health services. It also includes collective health measures, that is, services for health
education, disease prevention related to the actions of health determinants, and environmental health, as well as occupational and environmental health. These activities are carried out not only by health service providers, but also by government entities in municipalities and departments. PHC activities based on the actions of individuals were provided during the pandemic, while collective activities were stopped when there were high numbers of cases and were slowly reactivated as the case numbers declined. Decision-making was centralized to the national and territorial emergency committees that operate regularly across the country, and in its departments, districts and municipalities.

The normative response of the national government to the pandemic aimed to respond not only to health care needs, but also to conditions across other sectors that have an impact on health, aiming for continuity in the actions set out

Figure 1. Decennial public health plan dimensions, 2012

Source: Ministry of Health and Social Protection (2012)
How multisectoral policy and action are responding to COVID-19 in the Decennial Public Health Plan. These actions included activities that aimed to guarantee the continuous supply of food to the population and the social protection of special groups such as the elderly and children. They also included measures related to labour and socioeconomic protection, transportation, housing, public order, communications, and the protection of sexual and reproductive health for the entire Colombian population and for the country’s migrant population (OCHA, 2020).

It is important to note that more than four million people have migrated to Colombia from neighbouring Venezuela since 2015 as a result of social problems in that country. Almost half of these migrants (an estimated 1.8 million people) are now in Colombia, according to the National Migration Office and the R4V platform, increasing demand for additional social, health and economic services (R4V, 2021).

The country had a prolonged quarantine period (from 25 March to 31 August 2020), with strict initial isolation that included the closure of shops, the education sector and borders, which lasted until May 2020. A period of gradual reopening by sectors began in June 2020 and was completed in September 2020. This quarantine process and the subsequent reopening generated a socio-political discussion around a particular dilemma: whether to prioritize the economy or health – a situation that revealed cracks between the national government team and the governments of each of the country’s departments and districts (Hernández Rincón et al., 2021).

During this period, the social interventions of the national and territorial governments focused on the protection of the population with the greatest unsatisfied needs. Cash subsidies were provided to enable people to buy basic products and food was distributed in different locations. Other measures included subsidies to public services and the prohibition or suspension of evictions due to rent arrears. Flexible working conditions were introduced to allow people to work from home so that companies could gradually reactivate, aiming to maintain employment and family incomes. Each department and district had the autonomy to increase restrictions or improve protection measures, but no pooled data existed related to these measures.

In addition to the actions taken by the government for the population, actions were taken to protect the private sector and small businesses. These actions were intended to avoid unemployment and the collapse of companies and to safeguard the production of goods and services and the country’s income. However, they were not enough; the pandemic resulted in a significant increase in unemployment from 10.5% in January 2020 to 13.5% in January 2021, but with a significant peak of 24% between April and July of 2021, generated by the closures of small businesses and by a reduction in informal sources of work (DANE, 2021).

A rise in social inequalities, unemployment, domestic violence, violence against women and insecurity became more acute during the stage of the pandemic when movement restrictions were in force. This generated a complex social situation leading to protests against the national and territorial governments.
and acts of violence among citizens and against the authorities. This confirms the need for structural reforms that link all citizens to decision-making processes to achieve a proper social balance. While these protests were not aimed at the health sector in particular, they prevented Congress from changing some laws, including one on health reform that aimed to strengthen the implementation of PHC.

The private sector played a role in strengthening the response to the pandemic by participating in social aid and donating to the government’s efforts. The sector also collaborated with universities to develop important elements for the response, such as the industrial production of supplies for hospital care, including respiratory support equipment for patients in critical care units (WHO, 2020).

Health research, however, is a sector that is lacking capacity, together with the capacity for technological development, innovation in health, and the strengthening of structures that will enhance health autonomy and enable the country to face future challenges. Future research might be framed as part of Colombia’s development of practices and technologies for health, but also as part of wider social research to improve understanding of the culture of different regions in the country and the conditions that determine community decision-making processes and participation (Fog Corradine, 2020).

Engaging and communicating with communities effectively and leveraging community resources

Since 1991, Colombia has defined a wide variety of participation mechanisms for health and other public sectors. The aim has been to immerse the population not only in the process of electing legislative representatives and the country’s leaders, but also in decision-making, monitoring and control of policies, plans and programmes that are executed in the national environment, and monitoring of the work of public institutions. However, low participation rates nationally in democratic electoral processes may limit the effectiveness of related participatory mechanisms.

The health sector is framed as a participatory process. It includes a variety of formal and informal spaces where citizens can take part in the process of planning, execution, surveillance and control of health standards, both in the activities that are developed from the national government as well as in the spaces at the level of the territories, the EPS and health service providers. Citizen participation in health is part of the Policy for Social Participation in Health (Resolution 2063 of 2017), which has five strategic axes for its implementation (Figure 2) (Ministry of Health and Social Protection, 2017a).

The participation process has two main strategies, the first one is to provide information to the community and include activities such as accountability processes, promotion of health culture and participation that is integrated into surveillance, such as citizen oversight departments. The second strategy involves
consultive participation and includes activities such as the epidemiological surveillance committee (which advises local and national governments) and the spaces for participation in decision-making (participation in board of directors of hospitals or in committees for the definition of the health benefit plan).

Despite these mechanisms, there is no specific or adequate policy for participation in health based on real interaction and two-way processes, i.e., from the institutions towards communities, and from communities towards institutions. There are real gaps in terms of effective participation in Colombia’s informational, deliberative decision-making and control mechanisms (Ministry of Health and Social Protection, 2017b).

One example that illustrates the dynamics of the population in terms of participation and the flow of information to and from communities is the dissemination of fake news about COVID-19, the measures taken by the government and the actions of the different sectors to control the pandemic. While universities and the media played a role in disseminating good-quality information, social networks or rumours spread by word of mouth within communities resulted in the sharing of incorrect information and in community leaders not being able to prevent chaotic situations in these contexts.
A study by the Health Economics Group of the University of Antioquia on the governance of the health system finds that community organizations are among the actors with the lowest evaluation for their participation in the management of the pandemic. The study also finds that participation was not very effective, despite individual examples of social participation, and that a national body with advisory functions should be created to support strategic decision-making at the government level (Restrepo Zea & Zapata Cortés, 2021).

The strengthening of community participation requires a set of activities to develop the strategic axes of the National Policy for Social Participation in Health. These include education and skills-building for three essential actors: local health personnel and health teams in general, to understand the autonomy of the patient and the community as a determinant of the provision of health services; leaders of the institutions that provide health services and insurance entities, to develop mechanisms for the effective participation of the community in decision-making processes; and, above all, communities themselves, so that they are represented and can shape decisions on improved health services. In short, there is a need to build and reinforce a culture of participation to inform health decision-making.

The strengthening of community capacity through health managers is one of the most important developments contemplated by the MAITE Model and the normative approach that is taking place in PHC in Colombia. This approach has been gradually tested in some areas of the country, and it aims to ensure that health managers not only have a role in supporting the community to identify risks and serve as a link between the communities and the health services, but that they are also active in territorial spaces of participation, such as local health committees, alliances of users of health services and in citizen oversight committees (Ministry of Health and Social Protection, 2019a).

In addition, it is important to strengthen citizen culture by making use of telehealth tools. This includes the identification of the differential conditions of the population, of technological infrastructure, and of the best ways to support and promote a cultural change in health teams that favours the appropriate use of tools according to the specific context (Restrepo Zea & Zapata Cortés, 2021).

In essence, Colombia has developed multiple scenarios for the interaction of society, communities and the entire population with health services. Yet institutions, people on health teams and the communities themselves are not adequately prepared to use the scenarios created to this end. One challenge emerging from the pandemic, therefore, is the need to develop strategies that will build a culture of citizen participation for the effective enjoyment of the rights of individuals and communities, with adequate mechanisms for representation mechanisms and the formal and informal dissemination of information to shape decision-making.
Conclusions and lessons learned

The COVID-19 pandemic and the response of Colombia’s national government, different public institutions (local governments and hospitals) and private institutions (EPS, private clinics and other sectors) have generated lessons that will enable the country to develop strategies and actions to confront such crises in the future. It is important to strengthen those that generated a good result during the pandemic to ensure that they are sustainable in the long term.

One of the first interventions that could be strengthened is the automation of information management processes for decision-making. The development of dashboards with sentinel indicators to improve actions and the response of the national government to the different stages of the pandemic is one of the most outstanding examples. Further analysis of the factors that led to the success of these activities would help to inform their integration into the provision of health services on a day-to-day basis, in a way that enhances transparent management of services.

There are also opportunities to maintain and strengthen telehealth, from the use of education and risk management tools at the community level, to collaboration in the processes of middle- and high-complexity health care, and from special services and support from hospitals with larger care capacity and high-level experts to institutions with less capacity for the management of health services. This process could include not only technical and technological capacity but also the cultural transformation of patients, health professionals and the wider population to ensure adequate acceptance and adherence to a telehealth model.

Implementation of the National Policy for Social Participation in Health could include a roadmap that allows work at the macro, meso and micro levels in the health system. At the macro level, this would involve a shift from one-way dissemination strategies to an active invitation to learning and the greater participation of communities in decision-making. At the meso level, it would entail strengthening the technical, technological and cultural capacity of teams in both public and private territorial institutions to dialogue, deliberate, agree and implement work with the community. And finally, implementing the policy would mean equipping the community with adequate knowledge for effective and constructive participation, aiming to bring the population closer to the health system, beyond disease diagnosis and treatment.

The need for health system change to strengthen implementation focused on prevention and the interaction of health with other sectors and the importance of social determinants for health was reinforced during the pandemic. There is no tension between health and the economy: indeed, there is a clear link between the health needs of the population and the development of society. This suggests the need for work at community level and with health professionals on the implications of the social determinants approach to health. This cannot remain an exclusive discourse among public health professionals.
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The focus of change in Colombia’s health policies can promote a strengthening of research, innovation in health and also of the production of goods (technologies) for the provision of health services. These could include not only advanced technologies, but also basic technologies to support the routine provision of health services, such as elements of protection for citizens and health professionals, as well as medicines and some medical devices among others.

Strengthening research would also promote spaces for technological development for the country, adjusted to the needs of its society. This could include the development of tools that make it possible to solve day-to-day problems and strengthen the transfer of information. It could also include the development of new knowledge and technologies that improve health care in prevention, diagnosis and treatment scenarios and that promote health autonomy in the country under normal conditions and in times of crisis, such as the crisis generated by the COVID-19 pandemic.

In summary, there is an opportunity for the institutions that represent the national government and citizens to work more closely together and continuously to ensure that public policies are transformed from paper to practice. Long-term collaboration is needed to ensure the these policies produce the impacts that they are expected to deliver, to achieve better health of the population, generating trust among the different actors, and improving transparency in the management of institutions and social organizations.
References


This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic, applying the Astana PHC framework considering integrated health services, multisectoral policy and action and people and communities. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.