This is the published version of a paper published in *International Journal of Health Planning and Management*.

Citation for the original published paper (version of record):

http://dx.doi.org/10.1002/hpm.2228

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Permanent link to this version:
http://urn.kb.se/resolve?urn=urn:nbn:se:umu:diva-83481
Challenges of implementing a primary health care strategy in a context of a market-oriented health care system: the experience of Bogota, Colombia

Paola A. Mosquera1,2,*, Jineth Hernández2, Román Vega2, Ronald Labonte3, David Sanders4, Kjerstin Dahlblom1 and Miguel San Sebastián1

1Department of Public Health and Clinical Medicine, Epidemiology and Global Health, Umeå University, Umeå, Sweden
2Postgraduate programs in Health Administration and Public Health, Pontificia Universidad Javeriana, Bogota, Colombia
3Institute of Population Health, University of Ottawa, Ottawa, Ontario, Canada
4School of Public Health, University of the Western Cape, Bellville, South Africa

SUMMARY

Background Although Colombia has a health system based on market and neoliberal principles, in 2004, the government of the capital—Bogota—took the decision to formulate a health policy that included the implementation of a comprehensive primary health care (PHC) strategy. This study aims to identify the enablers and barriers to the PHC implementation in Bogota.

Methods The study used a qualitative multiple case study methodology. Seven Bogota’s localities were included. Eighteen semi-structured interviews with key informants (decision-makers at each locality and members of the District Health Secretariat) and fourteen FGDs (one focus group with staff members and one with community members) were carried out. Data were analysed using a thematic analysis approach.

Results The main enablers found across the district and local levels showed a similar pattern, all were related to the good will and commitment of actors at different levels. Barriers included the approach of the national policies and a health system based on neoliberal principles, the lack of a stable funding source, the confusing and rigid guidelines, the high turnover of human resources, the lack of competencies among health workers regarding family focus and community orientation, and the limited involvement of institutions outside the health sector in generating intersectoral responses and promoting community participation.

Conclusion Significant efforts are required to overcome the market approach of the national health system. Interventions must be designed to include well-trained and motivated human resources, as well as to establish available and stable financial resources for the PHC strategy.

© 2013 The Authors. International Journal of Health Planning and Management published by John Wiley & Sons, Ltd.

KEY WORDS: primary health care; barriers and enablers; qualitative study; Bogota

*Correspondence to: P. A. Mosquera, Department of Public Health and Clinical Medicine, Epidemiology and Global Health, Umeå University. SE-901 87 Umeå, Sweden. E-mail: paolamosquera@gmail.com

© 2013 The Authors. International Journal of Health Planning and Management published by John Wiley & Sons, Ltd.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
INTRODUCTION

Primary health care (PHC) is enjoying renewed interest thanks to the fact that its values and comprehensive approach to health system organisation, as first expressed in the Alma-Ata declaration, are currently promoted by the World Health Organization (WHO) (PAHO/WHO, 2008). It is also increasingly accepted that socioeconomic, political and cultural factors, as well as power relations and political processes, shape the implementation of health policies, health system reforms and the comprehensiveness and effectiveness of PHC (Buse et al., 2005; Labonté et al., 2008). The 2008 WHO report called for further evidence to identify the technical and political obstacles to PHC advancement and implementation (PAHO/WHO, 2008).

Although Colombia had a health system based on market and neoliberal principles, in 2004, the local government of the capital city—Bogota—made a decision to formulate a district health policy that included the implementation of a comprehensive PHC strategy (Alcaldía Mayor de Bogota/Secretaría de salud Distrital, 2004; Vega-Romero and Carrillo-Franco, 2006; Vega-Romero et al., 2008, 2012; Mosquera et al., 2012a, 2012b). The strategy aimed to improve the quality of life, increase the health status of the population, and to reduce health inequities (Alcaldía Mayor de Bogota/Secretaría de salud Distrital, 2004).

The PHC strategy has been implemented by three consecutive governments over the last 8 years. During this time, there has been a continuous political tension stemming from the differences between national and district policies. Although the national policies emphasise a profit-based and market-oriented health care system, the Bogota local government proposed a rights-based approach rooted in community participation, the empowerment of social groups and intersectoral work (Vega-Romero and Carrillo-Franco, 2006; Vega-Romero et al., 2008, 2012).

Recent studies on the experience of implementing PHC in Bogota indicate that the strategy has contributed to an improvement of health outcomes and a reduction in health inequalities, despite the adverse national context (Mosquera et al., 2012a, 2012b). However, research has also shown that the strategy has not achieved some of the expected goals, and the coverage of the strategy has stagnated in the last 3 years (Mosquera et al., 2012a).

Little attention has been paid to analysing the processes, actors, institutional context and the exercise of power involved in the development of PHC at local level. This study aims to identify the barriers and enablers of PHC implementation in Bogota. This analysis should provide a better understanding of the overall experience and inform future strategies, which seek to improve and scale-up PHC strategy to the national level.

BACKGROUND

National health policy in Colombia

In the mid-1980s, Colombia began to implement fiscal, political and institutional decentralisation reforms, which aimed to reassign government functions and responsibilities to
the national, departmental/district and municipal/locality levels. The central government’s role concentrated on policy design, regulation and public finance. Departmental/district governments assumed the regional planning, management and financial responsibilities. Municipal/locality governments took on the implementation of policy and public service provision (Glassman et al., 2009).

In the early 1990s, the national government developed market-oriented economic, social and health policies (Giraldo, 2007; Vega-Romero et al., 2009), transforming in 1993 the old National Health System into the current General System of Social Security in Health (GSSSH) (Republica de Colombia, 1993), which is financed through a combination of payroll contributions and general taxation (Glassman et al., 2009). This reform aimed to make the system more efficient by reducing the state’s role as health care provider, decentralising health service administration to local governments, privatising health and increasing labour market flexibility (Corcho et al., 2000; Laurell, 2010). These changes sought to facilitate market competition and to increase the profitability of health care enterprises. The process excluded state actions on the broader determinants of health and dismissed the original principles of PHC. This resulted in a model that mixed managed care and health care assistance, promoted a biomedical and selective model of primary care and focused on the prevention of individual risk (Vega-Romero et al., 2009).

In the GSSSH, individual health care services are the responsibility of insurance companies, whereas public health activities are the responsibility of the local government health authorities (Corcho et al., 2000). Individual health care services can be provided through either a contributory regime for those able to pay, where formally employed and independent workers contribute a proportion of their incomes, or a subsidised regime, funded by general tax revenue, where poor people do not make any insurance contribution. People are usually enrolled with public or private insurers and receive care from a mix of providers. Those still uninsured and classified as poor only have free access to emergency care (Glassman et al., 2009).

Individuals in both the contributory and subsidised regimes receive a health benefits package. Public health programmes are provided through a collective intervention plan—‘Plan de intervenciones colectivas’ in Spanish—which complements health care insurance. Local health authorities provide health promotion and disease prevention services included in the collective intervention plan through contracts between health secretariats and public health providers (Glassman et al., 2009). Figure 1 summarises the GSSSH structure.

_Bogota’s health policy_

The centre-left government, elected for first time in Bogota in 2004, developed a district health policy intended to guarantee the right to health and to address the social determinants of health inequalities. Two of the main strategies put in place in the health sector were the promotional strategy of health and quality of life (PSHQL) (Estrategia promocional de calidad de vida y salud in Spanish) and the PHC strategy (Alcaldía Mayor de Bogotá/Secretaria de salud Distrital, 2004; Alcaldía mayor de Bogotá/Secretaria de planeación, 2004, 2008; Vega-Romero et al., 2008, 2009).
The PSHQL was conceived as a public management approach, which aimed to improve the quality of life of the population through health sector collaborations with other sectors. The PSHQL strategy organises public health actions into four categories: (i) activities revolving around daily life (families, neighbourhoods, schools and workplaces); (ii) interventions through the life course (from childhood to old age); (iii) activities to address transversalities (gender, equity and diversity); and (iv) projects to develop community autonomy (Secretaría Distrital de Salud de Bogotá, 2010).

The PHC strategy, in turn, was based on a comprehensive approach and was designed to reorient health care delivery to ensure better access and the use of services (Alcaldía Mayor de Bogotá/Secretaría de salud Distrital, 2004; Secretaría Distrital de Salud de Bogotá, 2010). Operationally, the core of the PHC strategy is the home health (Salud a su Casa) programme. This programme currently works within the network of first-level public health care facilities operating under the authority of the Bogotá District Health Secretariat (DHS). It includes basic health care teams, comprised a physician, a nurse, two community health workers and an environmental technician who provide either intramural or extramural services (Alcaldía Mayor de Bogotá/Secretaría de salud Distrital 2004; Vega-Romero et al., 2009; Secretaría Distrital de Salud de Bogotá, 2010). Aiming for progressive coverage, the intervention began by prioritising poor people classified as belonging to social strata1 1 and 2, with the aim of gradual expansion to other strata in the future. Individuals enrolled in the home health programme are more easily given appointments in healthcare centres and hospitals and have easier access to social programmes, such as community kitchens,

1Strata is a socioeconomic measure that classifies population by groups from 1 to 6, 1 being the lowest and 6 the highest. As in the rest of Colombia, Bogotá’s population is classified by social strata.

© 2013 The Authors. *International Journal of Health Planning and Management* published by John Wiley & Sons, Ltd. DOI: 10.1002/hpm
housing subsidies and education grants for children who have left school. The promotion of and support for social mobilisation and the strengthening of education and defence of the right to health are additional attributes of the programme.

**Actors involved in the implementation of the primary health care strategy**

Implementation of the PHC strategy takes place within the structure of the GSSSH and is monitored by the Ministry of Health, which is responsible for the coordination of the District health authorities. Decentralisation within the Colombian health system allows district authorities to design their own policies and strategies, as influenced and shaped by guidelines from central government. In the case of Bogota district, the mayor heads the city’s government. The DHS is responsible for designing the operational guidelines for health policies and for planning and executing the monitoring processes at the local level. At locality level, there is a local mayor appointed by the district mayor from a list of candidates provided by the administrative boards of each locality, members of which do not necessarily come from the same political party. Public hospitals are in charge of operationalising public health interventions. Members of the health care teams are responsible for working directly with the community to provide services. Institutions working in education, culture, social welfare and the environment can also collaborate and establish partnerships with public hospitals to implement intersectoral actions. Communities play a central role, through community-based organisations, in mobilising intrasectoral and intersectoral actions. Figure 2 shows a list of actors involved in the PHC implementation.

**METHODS**

**The setting**

Bogota is the capital of Colombia and has 7,571,345 inhabitants (2012). It is divided into 20 localities, of which 19 is urban and one is rural, and four networks of health services (north, south, east central and south western). About 51.2% of the population is classified as being in strata 1 and 2, the two lowest socioeconomic strata. By 2010, the home health programme had achieved 40.36% coverage (1,497,750 people) of the population in these two strata through the establishment of 358 basic health care teams. The development of the PHC strategy in Bogota showed a notable initial increase in home health programme coverage between 2004 and 2007, followed by a period of slower growth between 2007 and 2010 (Mosquera et al., 2012a).

**The study design**

The study used a qualitative multiple case study methodology. Multiple case studies are variations of case study methodology allowing researchers to explore phenomena through the inclusion of various units of observation (Yin, 1994). Given that Bogota’s PHC strategy is a complex intervention that is context dependent and
involves several social processes, we determined that a multiple case study approach was the most appropriate methodology.

Seven localities belonging to the four different geographic health networks were included in the study. These were chosen as a set of representative cases of the phenomenon to be analysed (the home health programme), because these localities showed similar trends to those of Bogota as a whole (a significant increase in the coverage of the programme during the first 3 years of implementation and subsequent stagnation). Their large and diverse population was a second reason for selection (approximately four million people—57% of the total population of Bogotá and 80% of the total population classified as strata 1 and 2 are in these seven localities). The third reason was because of their role as early adopters of the home health programme. The study used a purposive sampling strategy to identify key informants on the basis of their individual roles within the health institutions and communities. This allowed us to explore a broad range of perspectives on issues emerging, as we aimed for maximum variation in our sampling.

**Data collection and analysis**

The data collection was conducted between August 2010 and March 2011 and included 18 semi-structured interviews with key informants (two decision-makers at each locality and four members of the DHS staff) and 14 focus group discussions (FGD) of 7–10 people per group. Two FGDs were undertaken in each of the 7 localities, one with staff members of the home health programme and one with community members. An interview guide was developed for the semi-structured interviews, and another guide was developed for the FGDs. Both guides included open-ended questions (e.g. how the PHC strategy was introduced in the locality? what were

Figure 2. Actors involved in the implementation of the primary health care strategy
the main concerns about the PHC operationalization? which stakeholders played an important role in the process and how such roles influenced the scope and development of the PHC strategy?) that aimed to explore enablers and barriers during the process of the PHC implementation. A field research team comprised five people performed the interviews and focus groups. Consistent with qualitative research methods, interviewers maintained an open stance, probing emerging issues and asking for further explication or clarification when necessary.

All interviews and FGD were tape-recorded, transcribed and were used as the key texts for analysis. Transcripts of the original text in Spanish were entered into open code software (ICT Services and System Development and Division of Epidemiology and Global Health, 2009) for the coding process. Data collected were examined by first identifying topics and then grouping similar topics together to form emergent categories. Analysis of the data was performed for each locality separately, and then the findings were integrated into the overall emergent categories and themes. Data were analysed using a thematic analysis approach (Fereday and Muir-Cochrane, 2006).

Two researchers (the first and second authors) carried out the analysis independently, finding no significant discrepancies in the identified categories. As the objective of this research was to identify barriers and enablers to the PHC implementation, categories were grouped into these two themes. The findings were then discussed by the entire research team to develop the analytic conclusions further. Finally, in a post-study workshop, the preliminary findings were presented to study participants to give feedback and to validate the analysis. Some views held by stakeholders were discussed and clarified, and the main results of the analysis were confirmed in this member-check workshop.

The Walt and Gilson policy analysis framework (Walt, 1994; Walt and Gilson, 1994) provided a guide for the data analysis. This framework recognises that the health policy process involves four interacting elements: context, process, actors and policy content. The assumption is that actors are influenced (as individuals or members of groups) by the context in which they live and work. Context is affected by many factors created by politics, historical experiences and culture, and the process of policy-making is in turn affected by actors. The content of policy reflects some or all of the elements mentioned previously (Walt, 1994; Walt and Gilson, 1994).

**Ethical considerations**

This study was approved by the Ethics Committee of the Department of Postgraduate Programmes in Health Administration and Public Health, Pontificia Universidad Javeriana, Bogotá. The study was presented to the boards of all hospitals involved and was approved by them before the field work was initiated. Oral informed consent was sought from all participants after explaining the objectives of the study; they were assured of their right to withdraw from the interview or the FGDs at any time. Interviews and FGDs were recorded with the permission of participants, and recordings and transcripts were stored confidentially.
RESULTS

Analysis of the interviews and FGDs identified a wide range of factors that influenced the PHC strategy implementation. For the presentation of the findings, we have organised these factors into two main themes, enablers and barriers to the PHC strategy implementation. Within the themes, factors are grouped to reflect the interaction between the four elements proposed in the Walt and Gilson’s policy analysis framework.

Enablers of implementation

(i) Long term political continuity

There was consensus among decision makers, staff members of the DHS and members of the home health programme that the continuity of the same political party in the district government was important in keeping the PHC strategy high on the political agenda. This political continuity allowed policy maintenance, which facilitated the implementation that led to the positive results so far achieved and which are reported elsewhere (Vega-Romero et al., 2008, 2009; Mosquera et al., 2012b, 2012a). All of the actors at district and local levels understood the PHC principles as a political process not tied to a particular government programme. Members of the DHS also mentioned that the dynamic changes at district level created the political agency necessary to visualise the PHC strategy at national level, which successfully kept the strategy on the agenda of priorities. One of the informants stated:

‘…it has not been an easy process, when the city began to implement the PHC strategy, everybody strongly criticised the political approach, saying that we were duplicating efforts, substituting the role of insurers, carrying out a parallel health system. However the political will and agency by the Mayors as well as by the District Health Secretariat has been successful. In 2005–2006 the PHC strategy reached greater visibility in all levels and the approach of the district health policy was accepted by local mayors, hospitals and even stakeholders at the national level. Nowadays no one questions the strategy and the national government is already thinking about scaling up the primary health care principles to a national level’ (Interview-DHS official)

(ii) Support from local mayors and hospital managers

At the local level, an enabling factor identified by the DHS and hospital staff was the support from local mayors and hospitals managers for the PHC strategy. In their opinion, this became very important because of the extent of decentralisation of the health system in Colombia; thus, although there was a general guideline issued at the district level, the level of importance given to the PHC strategy and its placement within the institutional structure was primarily a local decision.

A good example of the commitment from some local mayors was the reallocation of some local resources to support the strategy (additional resources to those allocated directly through the CIP). Another example, at the hospital level, was the decision taken
by some managers to formally include the principles and values of PHC in their strategic platforms and models of care management. Some respondents expressed it this way:

[...] to have additional resources from the local mayor helped a lot to increase the number of teams and the home health coverage, also the support from the heads [referring to managers] who have understood that PHC goes beyond the home health programme, helped to transform the organisation of the whole hospital… without the support of the heads it would be very complicated for us [referring to the staff] to give to the strategy the level of importance required and would be an organizational burden that was not worth it. (Focus Group – Hospital Staff).

The home health care members interviewed confirmed that these types of support helped to improve the connection between actors involved at the local level, as well as all staff within the hospitals and not only those directly responsible for the strategy implementation.

(iii) Commitment of health care teams and community health workers

Members of the community recognised that the work, commitment and sense of belonging of the home health care teams helped to achieve greater visibility for the health sector and to increase community support for the program. This in turn helped to sustain local adherence to the PHC strategy, generating further political support. Informants from the community also perceived an improvement in access to the health care system as well as positive short term results from intersectoral actions aimed at meeting community needs. Health care teams were especially valued by PHC users—especially the work of, and guidance offered by, community health workers. This can be exemplified by the following quotation from a community member:

This commitment that we saw in the staff of the home health care teams… They come and get muddy. Meanwhile we saw staff from many other institutions coming around and just give us a glance without getting out of their cars so they didn’t have to set a foot on the floor… and community health workers from the home health programme came to our houses, and asked what happened? Did you know the son of your neighbour got sick? Come on, you have to be a team, friends, colleagues… and let me help you, I will teach you how to care for your children when they are sick, I’ll give you a reference for an appointment at the health care facility… so all this support motivated us and we agreed to ask the government to maintain the strategy. (Focus Group – Community member)

(iv) Organised communities

Managers and home health care team members identified the involvement of organised communities that have been historically committed to the process of social participation as a key factor that facilitated the implementation of the PHC strategy. From their point of view, these empowered communities were key to beginning the process, because they had already identified needs and had some experience about
how to generate comprehensive responses and work together with institutions. A home health care team member said:

[...] and we realize in this locality the community had a huge history in participation, let’s put it in terms of numbers 17,000 people came to the general citizen meeting [event promoted by Bogota’s mayor] and we thought then this locality moves people and not only because of the PHC strategy but from before. This was a historic fact that allowed the mobilisation of the community and they helped us to identify places within the neighbourhoods to open new community health care centres, the school found a room and the leader of the Community Action Board lent us an office… this is an example of a very strong social mobilisation which made our work easier. (Interview - Home health care team member)

According to the home health care team members, the co-responsibility previously developed in participatory communities allowed the establishment of interventions as well as supported the continuity and sustainability of old and new ones.

*Barriers to implementation*

(i) *The fragmentation and segmentation of the GSSSH*

Structural factors related to the national health system itself were considered one of the most important barriers to PHC implementation. According to the perceptions of DHS staff, the division of functions, the fragmentation of actions as well as the reduction of the state role (i.e. in financing, stewardship and health services delivery) resulted in a district health policy that limited its influence to the network of first-level public health care facilities. One respondent from the DHS expressed this barrier as follows:

Who has control over insurer companies hmmm? … If the stewardship of the District Health Secretariat is a ‘salute to the flag’, we have serious problems with the contracts of subsidised insurance companies, because there are no specific tools with which we monitor and control them. And what to say about the contributive insurance companies where the DHS has no influence… and we have not support from the national level, no one give us any answers about how to manage, control and monitor. (Interview - DHS official).

Members of the home health care teams confirmed the structural problems, saying that the public–private combinations of providers and insurers along with the regulated competition scheme have meant that both public and private institutions compete for resources, neglecting community needs. A respondent in a focus group was concerned as follows:

The PHC strategy does not fit into the system in which it has to work, and this is related to the way the system is organised, with its rationality… insurers, providers, hospitals and institutions have to fight to find resources and survive within the market. Then the implementation of the PHC strategy is tied to selling services and to gaining resources… we lose sense of direction [referring to the goals of the implementation process] because we are not working to solve community needs, but to achieve financial sustainability. (Focus Group – Hospital staff)

The segmentation and fragmentation of care originated in the different insurance schemes with different benefit packages, were identified for some members of the home health care teams as a strong limitation to achieving some of the essential dimensions of the PHC strategy:

I believe the health insurance scheme and the segmentation in contracts are critical issues. What did we start to see with the Home Health care teams? In the same house, the father was enrolled to one regime and the mother with another, one of them was not capitated with us, then what could we do with this fragmentation? Well, tell the mother you have right to get the appointment but you mister cannot come to my hospital because your insurer doesn’t have any contract with me… another example, I found a pregnant woman and she came to receive antenatal care but I could not do the HIV test because the insurer does not include that test in the contract, so the pregnant woman had to go from here to Simon Bolivar [Hospital 1 hour away] where the insurer was contracted to do the HIV test. What kind of comprehensive services could we offer this way? (Focus Group – Hospital staff)

(ii) The lack of stable resources

According to staff at the management level, the PHC strategy was limited by an important constraint on the financial sustainability of the hospitals. In planning the strategy, it was assumed that hospitals would finance some of the working time of professionals within the health care teams, with resources coming from the sale of services. However, hospitals have been facing a crisis in the last decade and most of them could not find additional resources to fund that professional working time.

In 2007, the PHC strategy went from being in a core position in the district health policy to being relegated to the activities concerned with daily life (families) of the PSHQL strategy. This move had economic implications, because it led to smaller budgets each year and also, in some localities, to mayors deciding to stop the additional funding previously allocated to the home health programme. An example of this view was expressed in the following quotation:

The budget is a real issue, if a hospital is in crisis, the money goes to the priorities and the decision would be to fire most of the people working in public health programmes and minimise the money invested in the PHC strategy… And unfortunately we have to talk about resources, about money, and when you have money you can do many things, but when the budget becomes smaller and the DHS starts to cut resources, we have to cut activities and fire people. (Interview – Hospital manager)

(iii) Guideline changes divorce theory from practice

The relocation of PHC to the PSHQL strategy was perceived by the home health care teams as a factor that weakened the process of implementation. Hospitals at the local level had to readapt their work, and the PHC operationalisation was reduced from its core position to focussing on the set of activities performed by home health
care teams within the family setting. A member of the health care team described this barrier as follows:

After we had gone to all that effort to implement PHC the DHS changed the guidelines, and PHC was not the core anymore, so yes again to make changes… we had to adapt quickly to the PSHQL, then we were wondering what will we keep from the PHC strategy? Well, just the Home Health programme and what does that mean? There is not a real PHC strategy, only one programme is not a true PHC. (Focus Group – Hospital staff)

Another limiting factor highlighted by the home health care team members was the lack of communication between those who designed the operationalisation guidelines at the DHS and those responsible for implementing the strategy at the local level. A conceptual separation was perceived between theory (principles, values and goals of the PHC) and practice (guidelines for operationalising the strategy). Home health care team members claimed that guidelines for the operationalisation of the strategy were often contradictory and overly rigid. The PHC strategy advocated generating comprehensive responses to community needs through the promotion of social participation and intersectoral actions (long-term goals); however, the guidelines had very tight schedules and short-term goals, which did not give enough time for hospitals to work together with communities in the identification of needs and the generation of responses in a participatory way.

Professionals in home health care teams also claimed that instead of developing programmes and spending resources to meet community needs, the guidelines forced resources to be allocated to those programmes and interventions established by the DHS:

One thing is the policy, and another one is how the policy landed into operationalization guidelines, and there is a total divorce. The guidelines were confusing: how could someone sitting at a desk design guidelines without asking or thinking about how things happen in the field? And the goal within the guidelines is not a favour; you have to meet it, so if you do not do ten visits per day, man… we cannot pay to you, so kill or do whatever you want, but accomplish the goal, and when we identify this vulnerable population, we say this process needs more time, I need to organise meetings with the community, open proper spaces to listen to people, and communities have their own pace… but under the guidelines it is impossible to spend more time, otherwise I won’t meet the goal. (Interview – Home health care team member)

(iv) High turnover of workforce

The lack of stable resources and the constraints imposed by the national policy of labour market deregulation and flexibility, together with the imperative of financial sustainability faced by hospitals, have resulted in a high turnover as well as a lack of adequate on-going training for the health workforce. Health workers faced unsatisfactory working conditions such as temporary contracts without social security (from semi-dependent to self-employment), poor remuneration and work overload.

© 2013 The Authors. International Journal of Health Planning and Management published by John Wiley & Sons, Ltd. DOI: 10.1002/hpm
The people working at different levels often felt mistreated and discouraged. The following quotes from some respondents illustrate the point:

These forms of contracts have maltreated people and people are not motivated to work, then they don’t do their best. Sometimes when the contract ends the hospitals leave people waiting 1, 2 and up to six months to renew a contract. Then when you find a chance to work in other places, you go away and we have a high turnover, between 80 to 85% of the people change between January to June each year. Besides the poor labour conditions, hospitals hire professionals to work on more than one project, only one person for three and four projects, another example, the hospital gets a contract for a product to be completed in twelve months but they hired me just for four months, then the overwork creates schizophrenia in people. (Focus Group – Hospital staff)

To the extent that there is a huge turnover, then PHC processes developed with the community are lost, because the adhesion of the community to the process depends on trust, and people recognise the staff but when a new worker comes each three or six months they have to start the whole process again. (Interview – Home Health care team member)

According to home health care team members, the high turnover was also an important factor at the managerial and coordination level, disturbing the organisational climate, stagnating and reversing part of the process of policy advocacy at district level. One member expressed it this way:

The logic is that the person goes away but the process will continue and it is a lie, the person goes away and the process dies. Look how important people are, when the chief of social participation goes away, we have not a head anymore that goes and talks to other heads. We had opened a doorway through her, we were the crew and we made the proposals, and she did all the coordination with the heads of the other sectors because she was a significant figure of connection, she talked to the director or manager of many institutions, when she went away we lost that power and our work decreased its scope. (Interview – Home Health care team member)

Training and skills development was initially undertaken by the DHS and hospitals; however, budget constraints gradually reduced the investment in training. Because of the high turnover already mentioned, the well-trained staff moved to another jobs. A staff member of the DHS expressed the problem in this way:

Universities do not train students to do community work, training has a clinical and individual approach, and so it is very hard... if they came already trained by the university then it would be easier for them to work, if universities were involved with the strategy, the training process would not be only a responsibility of hospitals and the DHS, and what to say about the high turnover of the health human resources... look, people trained in 2006 with international teachers who are no longer at hospitals, and the hospitals do not have money for ongoing training processes, so when new people come to work they just read these booklets and interpret them on their own and then begin to do what they can. (Interview - DHS official).
(v) **Coordination problems**

From the standpoint of Home Health care team members, the process of coordination with actors from other sectors had made initial advances. At the beginning, institutions agreed to have a joint periodical meeting among all stakeholders to identify needs and design collaborative interventions. However, some institutions did not give enough importance to the need for joint action, showed no interest in the process or just lacked sufficient staff to attend the meetings promoted and led by the hospital. This became a constraint, because failing to involve all actors and institutions at local level resulted in an inability to generate comprehensive responses to solve community needs. A member of the home health care team had this to say:

> All started with the good will of people, but those people somehow represent institutions. We started holding some meetings, but were unable to continue them, because it was infertile ground for achieving what we wanted, some institutions do not want to be involved so even if people wanted to, they could not because they depend on institutions and we did not find support from some institutions. (Interview – Home Health care team member)

(vi) **Instrumental community participation**

Although some communities were organised and historically active in participation, in many localities, community participation was dominated by the individual interests of their leaders or influenced by other district institutions and political parties. According to some home health care team members, communities abandoned collective goals when they realised they could receive private benefits.

> We do not need to tell lies, the community leader realises he can get a job for his son, or a new business for his family, help to build a house for his daughter or just shirts, jackets or lunch… then some institutions take advantage of this situation and keep the leader happy and he in turn calms down people at community and this way the community won’t come to claim their rights. (Interview – Home Health care team member)

People in the community on the other hand identified the decision-making process as divided, one space where political parties and institutions discuss problems and take decisions and another separate space where the community identifies their needs and discusses possible solutions. This division in meetings made communities feel undervalued in their role. When community interests coincided with the interests of politicians, participation served as a way of legitimising the actions; however, when interests did not converge, particular political interests prevailed. A member of the community explained it in this way:

> We realize there were two tables [Agendas] in the process, in one, sectors and institutions identified problems and generated responses and in the other community talked about their problems, but where were the decisions taken? And what could the community do? We did not see results in this process, so we started to stand aside… We did some analysis, we must not be a genius because is obvious,
institutions have used us, so, please come and sign to confirm you agree… agree with what? With what has already been decided? With what is already tied? Then, it is a thing that discourages the community. (Focus Group – Community member)

DISCUSSION

This study provides a snapshot of the different facilitators and barriers affecting the ongoing process of PHC implementation. The findings illustrate the challenges ahead and the actions or interventions needed to support the implementation process of PHC.

The main enabling factors found in this study across the district and local levels showed a similar pattern; all were related to the good will, and the commitment of actors at different levels of PHC implementation (Bogota mayors, staff at DHS, local mayors, hospital managers, health care teams and participating communities) to promotes changes and make a difference, not only to successfully implement the strategy but also to encourage mobilisation processes that could empower people and communities.

Despite the difficulties of implementing PHC in a context of health system fragmentation and segmentation, all actors recognised that the change in the orientation of the district policies and the commitment of the last two mayors generated a new policy environment. This created room for local governments and public hospitals to reorient their models towards a framework of values and principles, which involved a renewed way of working that went beyond the curative health care approach. This change had a positive impact on the attitudes and vision of the institutions, staff and communities. Studies have shown how modifications in legislation and policies adopted by governments and health authorities act as enablers to generate shared goals, which facilitate collaborative work in PHC (West, 2011). WHO has also highlighted the importance of policymaker commitment and their role as facilitators to achieve the goals in PHC reforms (PAHO/WHO, 2007).

An enabler deserving special recognition, and that has facilitated the continuity of PHC implementation, has been the political and economic support from local mayors and the management of the hospital managers who obtained additional financing resources to expand the home health programme coverage in their localities. The establishment of basic health care teams and the extramural work of professionals, community health workers and technicians with a high level of commitment were also identified by the community as key achievements. Community health workers have been especially recognised worldwide because of their capacity to make valuable contributions to community development, to improve access to health services, reduce costs to the health system by providing health education, as well as undertaking actions that lead to improved health outcomes (WHO/Lehmann and Sanders, 2007). In our study, managers and professionals within hospitals and communities especially valued the work of community healthcare workers. Their work has become more visible in the health sector, and this visibility, in turn, has contributed to community support for the continuation of the strategy.

As highlighted by many informants in our study, one of the most significant barriers to PHC implementation was the conflict between the national and the district health policy approaches. The former focused on market logic and the profitability associated with the sale of health care services, whereas the latter focussed on the promotion of health as a right. The two competing approaches generated an environment of constant tension where the national approach limited the establishment of the comprehensive PHC strategy reducing it, to some extent, to a programme underpinned mainly by activities performed by health care teams and community health workers (Vega-Romero et al., 2012). The difficulties in implementing and ensuring PHC sustainability in a fragmented and segmented health system such as the one in Colombia have been described in a literature review conducted in South America (Acosta et al., 2011). This review, as well as other studies, showed that in contexts where the health system has a mixture of public and private sectors and schemes of social insurance, as in Argentina, Chile, Peru and Ecuador, PHC is reduced in its application to vertical intervention programmes or isolated strategies with a transient nature (Vega-Romero et al., 2009; Ruiz-Rodríguez et al., 2011).

The lack of a stable source of funding was also identified as an important barrier in our study. The importance of ensuring adequate resources to meet desired PHC goals and to support health care teams has been noted in various studies as requiring special attention if the implementation and sustainability of PHC reforms and the development of collaborative intersectoral work are to succeed (Deber and Bauman, 2005; PAHO/WHO, 2007; WHO, 2010; Professional Collaboration/Pharmacy Guild of Australia, 2012). The PHC strategy in Bogota did not include in its planning full funding for the health care teams. To fill this gap, it was proposed that the hospitals should look for additional resources even when they were facing a situation of financial crisis. In addition, the imperative of financial profitability that is embedded in the planning process of all public institutions worsens the situation; public hospitals need to be financially sustainable, and in consequence, they tend to orient their activities to the selling of individual services rather than delivering public health interventions such as PHC, because those do not represent financial profits.

In addition to the funding problem, there is a lack of competencies regarding family focus and community orientation in many health workers. This is partly explained by the biomedical approach that prevails in the curricula of universities and technical health training programmes (Vega-Romero et al., 2009). Although the DHS and the hospitals attempted to overcome this barrier through a major initial investment in capacity building, the impact was limited because of the cuts in budgets and high turnover of human resources. Both the need to establish a permanent resource and the need to strengthen the training and retraining processes of the public health workforce have been pointed out as central elements of a sustainable PHC reform (WHO et al., 2001; PAHO/WHO, 2007, 2008; WHO, 2010).

Health workers in this study faced problems of unsatisfactory working conditions, temporary contracts, low wages, work overload and lack of economic and intrinsic incentives, resulting in a high turnover. These issues have been commonly reported as a major barrier to implementing health system reforms and collaborative PHC work, because they often cause people to lose their motivation and commitment. They also undermine any capacities for effective community participation and
engagement. One of the long established axioms of community work is that the worker is the instrument, and the qualities of the worker are far more important than the programmes or services the worker helps to broker (Labonté, 1998, 2010). To address these shortcomings, WHO has recommended staff incentive initiatives, changes in remuneration systems, investment in human resources through training and supervision and systematic actions in human resource management to encourage a stable workforce (WHO et al., 2001).

Contradictions and gaps within the operationalisation process were also identified as barriers. An important confusion was generated when PHC operationalisation was relocated to one of the daily life settings (families) within the PSHQL strategy. The amount and kind of activities included in the guidelines, as well as the short periods allocated to meet the requested goals, constrained the health teams in prioritising needs and formulating plans together with the communities. Continually changing guidelines have been identified in the literature as a barrier to generating inter-professional and collaborative work in PHC, as it requires a great deal of time and effort to plan and implement changes across multiple institutions and among many stakeholders at all levels (Deber and Bauman, 2005; West, 2011; Professional Collaboration/Pharmacy Guild of Australia, 2012). Rigid planning guidelines imposed by central authorities have also been recognised as a barrier to health care prioritisation processes, because they leave very limited space at the local level for planning activities and designing their own interventions according to community needs (Maluka et al., 2011).

Although historically active communities facilitated the PHC implementation process, power relations and planning processes are still based on institutions working in a vertical manner. A previous analysis conducted in Bogota has observed that the expected impact of transforming peoples’ health and living conditions through community participation was very limited, not because of the lack of will or organisation but because of structural legal factors and policy content that impeded a full community participatory process (Vega-Romero et al., 2009).

The difficulty of involving all actors at local level in the development of comprehensive responses was identified as another limiting factor. As per findings in other studies, insufficient communication between actors and different dynamics in institutions outside the health sector was present. Some staff from institutions outside the health sector perceived the effort of attending meetings regularly as a duplication of work creating operational delays. These problems could partly be explained by the lack of a clear role for each involved institution, which, in turn, negatively impacted the functioning of a coordinated team to generate intersectoral responses (Deber and Bauman, 2005; Professional collaboration, 2012). There is a large literature on intersectoral action for health, or what more recently has been described as a health in all policies approach. Similar to those found in our research, the main challenges for health in all policies are to successfully place health criteria on the agendas of policy-makers who have not previously considered health as part of the agenda and to convince other sectors to make health-related decisions. Designing policies based on shared aims and integrating impact assessment procedures would facilitate mutual gains to all sectors (Ståhl et al., 2006; Chomik, 2007; Leppo and Ollila, 2013).
With regard to the limitations of the study, the question of whether the conclusions reached are applicable to other Bogota localities is raised. Although the use of a multiple case design serves as a major strength of this study in identifying barriers and enablers by stakeholders in different levels, the use of the seven cases may have limited the scope for exploring factors affecting other localities. Although generalisability was not the intention, because local context is of vital importance to understand the processes when implementing a public health strategy, the experiences from this study can be transferable when evaluating similar interventions. The number of strategies used to improve validity—such as researchers as outsiders enhancing the willingness of actors to share information, independent coding and analysis by two researchers in the team, analytical conclusions shaped by a multi-disciplinary team and member-check on the results with the study participants—allowed a rich description that provides a valuable contribution to the knowledge of obstacles and facilitators to PHC advancement in Bogota.

CONCLUSIONS

This study has explored the challenges of implementing a PHC strategy in the city of Bogotá. The main facilitators were related to the long-term political commitment of the local government, the support of the local mayors and hospital managers, the sense of belonging of the home health care teams as well as the organised communities devoted to the process of social participation.

Barriers were identified at different levels. At the national level, the structure of the GSSSH itself, the educational and labour policies, the representative participation system and the overall rationale of the social policies based on neoliberal principles oriented to economic growth were core limiting factors. At the district level, difficulties were related to the reduction of the PHC approach by relocating it to the PSHQL, the confusing and rigid guidelines and its continuous changes, the lack of a stable funding source and the lack of connection of all actors (insurers and private providers). At the local level, barriers were associated with the high turnover of human resources and the limited involvement of institutions outside the health sector in generating intersectoral responses and promoting community participation.

Despite its limitations, it is important to recognise that the PHC strategy has arguably helped to make the health sector visible, to improve population health (Vega-Romero et al., 2008, 2009; Mosquera et al., 2012a) as well as to reduce health disparities (Vega-Romero et al., 2008, 2009; Mosquera et al., 2012b). The experience of Bogota has encouraged other regions to prioritise PHC in their health policy agendas, and the national government in 2011 launched a new law adopting the PHC strategy through the organisation of basic health care teams, the establishment of integrated networks of health services and the promotion of intersectoral action and community participation. This initiative seeks to involve insurers and providers as well as institutions outside the health sector (República de Colombia, 2011).

Significant efforts are still required to overcome the market approach of the national health system. Interventions must be designed so as to have well-trained
and motivated human resources, as well as to establish an available and stable source of financial resources for the PHC strategy.

ACKNOWLEDGEMENTS

This study was conducted under the project ‘Learning from the experience of PHC in Bogota and Santander’, which was funded by Colciencias, DHS of Bogota (Convention 693 of 2010 Fondo Financiero Distrital de Salud-Pontificia Universidad Javeriana) and by the Teasdale-Corti Global Health Research Partnership Program, a collaborative health research programme developed by the four founding partners of the Canadian Global Health Research Initiative—Canadian Institutes of Health Research, International Development Research Centre, Health Canada and Canadian International Development Agency—with input from the Canadian Health Services Research Foundation. This work was also partly supported by the Global Health Research Scholarship and the Umeå Center for Global Health Research, funded by FAS, the Swedish Council for Working Life and Social Research (Grant no. 2006-1512).

The authors have no competing interests.

REFERENCES


