

LEARNING FROM THE EXPERIENCE OF PRIMARY HEALTH CARE (IN BOGOTA)
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Objectives:

To Analyze the experience of implementation of Comprehensive Primary Health Care from the values and principles, management and achievements, with emphasis on the contextual factors that have limited or favored their performance. And, to analyze the results and evaluate the cost-effectiveness of the attributes of CPHC and its contribution to health outcomes and equity.

Methodology:

The investigation consists of: a qualitative study (multicase) in seven localities in Bogotá, a cross-sectional study at six locations, quasi comparative performance assessment of different actors in the public institutions that have implemented the strategy of PHC (exposed) and private institutions have not implemented (not shown), and a quasi-experimental ecological study that included 16 locations which identifies the possible effects of the implementation of PHC on health indicators and equity

Results:

The cases studied show that although the District Health Policy seeks to develop a comprehensive PHC, in practice we have implemented a hybrid model of PHC: comprehensive in that components such as community participation and intersectoral interventions targeted to operate cost effective and vertical, and basic care from the first level of Model atención.El identified is the result of ongoing tension between the factors of context, content and policy implementation process at different levels, reflecting interest opposing actors. The studied cases demonstrate that although the District Policy of Health seeks to develop a complete CPHC, in *practice* a *Hybrid Model of CPHC* has been implemented. This model is comprehensive in certain components such as communitarian participation and inter-sectionalism; while being selective when operating with interventions that are cost effective, of vertical character, and basic care from primary care. The identified Model is the result of the permanent tension between the contextual factors, policy content and the implementation process at different levels, that reflect opposed interests from the actors.

In terms of the performance of PHC attributes, respondents rated it as performing well or intermediate in both the public and private institutions. Critical attributes rated by users on both types of institutions were family focus and community orientation and for decision makers was the distribution of financial resources. Vocational training and access were rated as having average performance and other attributes were rated as good performance.

The trend analysis of health outcomes, suggest that the indicators improve (diminishes mortality and increase the prevalence of maternal lactose) as it increases the intensity of the CPHC. The *Poisson* regression models suggest a relationship between the increase of CPHC and the reduction from 13% to 15% of infantile mortality and mortality of those

below 5 years; reduction between 4% and 17% in the acute malnutrition and increase of 9% in the prevalence of breastfeeding.

Analysis of the changes in the distribution of the considered health indicators in both periods of observation (2003 and 2007) show effects associated with the CPHC in the reduction of inequity in health indicators, both through curves concentration as in concentration indices. CPHC has contributed in the reduction of infant mortality and in those below 5 years of age, as well as in the increase in the prevalence of breastfeeding with a greater impact in the populations with poor living conditions.

Conclusions:

Although the District Health Policy seeks to develop a complete CPHC, the tensions between the context and the content of the national policies and the districts have resulted in a Hybrid CPHC. The program SASC which implements CPHC has been reduced to a strategy based on the work of communitarian managers whose main objective is to induce demand for services and to promote community participation in identifying needs. Although advances have been identified in the access and comprehensiveness of services, these are still insufficient. There are weaknesses in the forefront, the bond, coordination, family focus, community orientation, training and human resource links, information systems and intersectoralism. PHC implemented in the city, despite its limitations, has managed to contribute to improving health indicators, and contribute to equity. It is important to consider that to achieve a comprehensive PHC and to meet the objectives proposed in the design of the radical political changes are needed to allow the PHC into the health system.