Gac Sanit. 2013;27(5):398–405

Original article

Awareness of the healthcare system and rights to healthcare in the Colombian population

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ARTICLE INFO

Article history:
Received 1 July 2012
Accepted 23 November 2012
Available online 16 January 2013

Keywords:
Healthcare systems
Healthcare rights
Health policy
Social determinants
Users' survey
Awareness
Colombia
Latin America

ABSTRACT

Objectives: To analyze changes in users' awareness of the healthcare system and of their rights to healthcare in Colombia in the last 10 years, as well as the factors that influence users' awareness.
Methods: We carried out a descriptive study to compare the results of two cross-sectional studies based on two surveys of users of the Colombian healthcare system. The first survey was performed in 2000 and the second in 2010. The municipalities of Tuluá (urban area) and Palmira (rural area) were surveyed. In both surveys, a stratified, multistage probability sample was selected. There were 1497 users in the first sample and 1405 in the second. Changes in awareness of the healthcare system and associated factors in each year were assessed through multivariate logistic regressions.
Results: Users' awareness of the healthcare system was limited in 2000 and was significantly lower in 2010, except for that relating to health insurers and providers. In contrast, more than 90% of users in both surveys perceived themselves as having healthcare rights. The factors consistently associated with greater awareness were belonging to a high socioeconomic stratum and having higher education.
Conclusions: The most underprivileged users were less likely to be aware of the healthcare system, hampering their ability to make informed decisions and to exercise their health rights. To correct this situation, health institutions and the government should act decisively to reduce social inequalities.

Conocimiento del sistema general de seguridad social en salud y de los derechos a los servicios de salud de la población de Colombia

Palabras clave:
Sistemas de salud
Derecho a los servicios de salud
Política de salud
Determinantes sociales
Conocimiento
Colombia
América Latina

RESUMEN

Objetivos: Analizar cambios en el conocimiento y en los factores que influyen en este conocimiento de los usuarios del sistema de salud (SGSSS) y de sus derechos a la atención en salud en Colombia en los últimos 10 años.
Métodos: Estudio descriptivo que compara resultados de dos estudios transversales basados en dos encuestas realizadas a usuarios del sistema de salud de Colombia, una en 2000 y otra en 2010. El área de estudio fueron los municipios de Tuluá (zona urbana) y Palmira (zona rural). En ambas encuestas se realizó un muestreo probabilístico estratificado multietápico, conformándose en la primera una muestra de 1497 usuarios y en la segunda de 1405. Se analizó el cambio en el conocimiento y los factores asociados en cada año mediante regresión logística multivariada.
Resultados: El conocimiento del sistema de salud en 2000 era limitado y en 2010 disminuyó significativamente, excepto en relación con las aseguradoras y los proveedores. En contraste, los resultados muestran que más del 90% de los usuarios en ambas encuestas se perciben poseedores del derecho a la atención en salud. Pertenecer a estratos socioeconómicos altos y estudios superiores se asocia consistentemente a un mayor grado de conocimiento.
Conclusiones: Los usuarios más desfavorecidos tienen menor posibilidad de conocer el SGSSS, lo cual es una barrera para tomar decisiones informadas y para hacer cumplir y ejercer sus derechos a la salud. Para revertir esta situación es necesaria una intervención decidida de las instituciones de salud, así como del gobierno en general, para reducir las inequidades sociales.

Introduction

During the late 1980s and 1990s, and under the influence of multilateral organizations like the World Bank and the International Monetary Fund,[1] numerous nations undertook reforms based on market models in their social sectors, including healthcare; Colombia was not removed from this. Thus, in 1993 the General System

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http://dx.doi.org/10.1016/j.gaceta.2012.11.012

of Social Security in Health (*Sistema General de Seguridad Social en Salud*, SGSSS) was created,[2] frameworked in the Political Constitution of 1991,[3] that did not grant healthcare the status of a fundamental human right but regarded it merely as an essential public service of obligatory compliance to be provided under state direction, coordination, and control. Stated principles of the SGSSS are[2]: universality, solidarity, comprehensiveness, equity, freedom of choice of health insurer and of healthcare provider, quality of service, and social participation.

With this reform, Colombia became one of the first middle-income countries to adopt a model of managed competition.[4] It created an extraordinarily complex healthcare system, made up of two insurance schemes: the contributory regime, for formal-sector employees and individuals with ability to pay, financed by mandatory contributions; and subsidized regime, for people unable to pay, funded by resources from the contributory scheme and other sources of financing, such as taxes. Health insurers were introduced to manage the contributory regime (*empresas promotoras de salud*, EPS) and the subsidized regime (*empresas promotoras de salud - subsidiadas*, EPS-S). Private insurers compete to enrol the population and public and private healthcare providers (*instituciones prestadoras del servicio*, IPS) for contracts with insurers. In 1994, a comprehensive policy for social participation in health was also formulated, which established participation in management, planning, and evaluation at various levels: from information to decision making[5] and through different types of health participation: citizen participation (based on a market approach), community participation and participation within healthcare institutions. In neoliberal models, participation is central: private enterprises are called upon to participate in managing and providing services, and citizens to participate, among others, in quality control: the latter is the focus of this article.

Users' awareness of the healthcare system, and of their rights to healthcare, empowers them for effective interaction with health services: for participating in various aspects of the healthcare system[6]; for making informed health decisions[7,8]; as well as for accessing services[9] and hence, it is one of the fundamental conditions for users to exercise their right to healthcare,[10] among others.

Therefore, user awareness of the healthcare system and policies, and of their rights are relevant social determinants of healthcare use, which are closely related to other social determinants, such as socioeconomic level, education levels, gender, and living in rural or urban areas, among others, and can lead to inequities in health.[11,12] Nevertheless, analysis of user awareness has been limitedly conducted, in general.[6] This also applies to Latin America with few researches available on user awareness of healthcare systems, their functioning, or their healthcare rights. Studies conducted in Colombia indicate that individuals of higher socioeconomic and education levels are those that best know the SGSSS,[13] and their right to healthcare.[14] Moreover, according to a recent analysis,[15] user's awareness of mechanisms for social participation in health in Colombia did not improve, but rather, tended to diminish during the last decade. This article seeks to analyze changes in factors that influence the users' awareness of the SGSSS and their rights to health care in Colombia in the last ten years.

Methods

Design

This descriptive study analyses trends[16] based on two cross-sectional studies carried out by means of two surveys among healthcare users who had used services within three months prior to the survey in 2000 and 2010.

Table 1
Socio-demographic characteristics of the samples: 2000 and 2010.

	Survey 2000 N = 1495		Survey 2010 N = 1405	
	n	(%)	n	(%)
Area				
Rural	727	(48.6)	689	(49)
Urban	768	(51.4)	716	(51)
Sex				
Male	543	(36.3)	618	(44)
Female	952	(63.7)	787	(56)
Socio-economic level				
Low	635	(42.7)	992	(71)
Medium	626	(41.8)	282	(20)
High	235	(15.6)	131	(9)
Education level				
No schooling-primary	702	(47.8)	918	(65.4)
Intermediate	628	(42.8)	426	(30.3)
University	138	(9.4)	61	(4.3)
Age (years)				
13-19	92	(6.2)	79	(5.3)
20-30	311	(20.9)	272	(19.4)
31-40	337	(22.6)	345	(24.6)
41-65	587	(39.4)	564	(40.6)
> 65				

Area of the study

The study area comprised two municipalities in the Department of Valle del Cauca in Colombia's Southwest: Tuluá, with 194,446 inhabitants and Palmira with 294,800 inhabitants.[17] Selection criteria were: having implemented the reform of the healthcare sector; including populations from all socioeconomic levels; high percentages of enrolment to the SGSSS; provision of all care levels; and, rural and urban areas.

Sampling

Sample size was calculated based on population size and expected rate of use of health participation mechanisms (estimated at 24% in year 2000, according to the pilot study, and at 25% in year 2010, according to results from the year 2000 study) and yielded a 95% confidence interval (95%CI) with 3% precision. The final sample was 1495 users in 2000; and 1405 users in 2010. The final sample comprised male and female users from different ages, socioeconomic and educational levels, and occupations (Table 1).

In both surveys, a stratified multistage probability sampling was conducted. In the first stage, neighborhoods –in the urban area–, and *corregimientos* (villages) in rural areas from different socioeconomic levels were randomly selected, without replacement. In the second stage, users were systematically selected. The sample range was calculated according to sample size and number of homes in each neighborhood; the initial home was randomly selected. The home was considered the primary sampling unit to avoid the effect of associated samples[18] in individuals belonging to a family. Efforts were made to interview the same number of men and women.

Questionnaire

For the 2000 survey, the questionnaire was adapted from a previous study[19] which was discussed with experts, and prior to its final version, it was submitted to a pretest and two pilot studies. It was a five-section structured questionnaire referring to: *a)* perceived quality of the services; *b)* awareness of the Healthcare System, participation policy, and healthcare rights; *c)* awareness of participation mechanisms; *d)* utilization and experience with such;