

# Strengthening user participation through health sector reform in Colombia: a study of institutional change and social representation

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The challenge of achieving community participation as a component of health sector reform is especially great in low- and middle-income countries where there is limited experience of community participation in social policy making. This paper concentrates on the social representations of different actors at different levels of the health care system in Colombia that may hinder or enable effective implementation of the participatory policy. The study took place in Cali, Colombia and focused on two institutional mechanisms created by the state to channel citizen participation into the health sector, i.e. user associations and customer service offices. This is a case study with multiple sources of evidence using a combination of quantitative and qualitative social science methods. The analysis of respondents' representations revealed a range of practical concerns and considerable degree of scepticism among public and private sector institutions, consumer groups and individual citizens about user participation. Although participation in Colombia has been introduced on political, managerial and ethical grounds, this study has found that health care users do not yet have a meaningful seat around the table of decision-making bodies.

## Introduction

In many developing countries, strengthening the participation of health care users in decision-making has been an important component of the health sector reform.<sup>1–3</sup> Increasing user involvement is thought by international and national policymakers to contribute to improved efficiency, equity and quality of health care delivery.<sup>2,4,5</sup> In Colombia and other Latin American countries where such reforms have been especially prominent, changes have been undertaken as part of wider transformations in democratic processes and political economies.<sup>2,6</sup>

There is a large body of literature concerned with participation in health which can be roughly classified into two opposing perspectives: participation as a means, and participation as an end in itself – also referred to as the technological or target-oriented, and the critical or empowerment approaches. In the former approach, people may not be expected to participate in identifying problems or designing a development programme, but are expected to serve the ends of professionals or authorities in charge of such programmes. The latter approach, conversely, emphasizes participation as a process in which confidence and solidarity among people are built up. This is defined as a social process by which individuals and groups seek to identify their needs and make decisions in order to establish mechanisms to meet them. Neither of these perspectives explicitly recognizes that the degree and form of people's participation depends significantly on the political and economic system in which it takes place.

During the 1980s, under pressure from social movements<sup>7–9</sup>

and the recommendations of national and international agencies,<sup>10,11</sup> the Colombian government introduced changes in the health sector. These included policies intended to accelerate decentralization, improve management capacity within the sector and increase community participation. The latter initiative advocated the need to empower communities in order to enable individuals to have greater control over decision-making through the implementation of primary health care strategy, the development of Local Health Districts and health promotion approaches.<sup>12–14</sup> In practice, it resulted in what Ugalde<sup>15</sup> defines as 'symbolic participation', whereby community involvement was largely confined to collaboration with the existing system and hence 'the legitimisation of low quality care for the poor'. Despite this limited initial scope, diverse legal mechanisms for user participation have been enacted since 1975, aimed at regulating and strengthening historical forms of participation (Decrees 350<sup>16</sup> of 1975; 1216<sup>17</sup> of 1989; and 1416<sup>18</sup> of 1990). The former participatory experiences took place in the context of a highly centralized state and a vertically integrated health system with multiple providers, and a large, centralized Ministry of Health.<sup>6</sup>

In the second half of the 1980s, participation in Colombia came to be seen as one of the main ingredients in modernizing the state, which required a new relationship between the state and society.<sup>19,20</sup> It was thought that the government should help the users of public services to have a stronger voice in investment, planning and service delivery, as well as ensure the accountability of local officials.

A combination of external and internal factors brought about the political momentum to formulate Law 100 of 1993, which

marked a profound change in the entire health system by attempting to materialize the goals embodied in the 1991 new Constitution,<sup>21</sup> i.e. universality, solidarity, quality, efficiency and participation. The social security reform, with a national health insurance programme, attempts to ensure universal access to a basic health care package with public financing.<sup>22–24</sup>

In 1993, Colombia became one of the first middle–low income countries to adopt a managed competition strategy to reform its health care system.<sup>25,26</sup> The reform process has taken on most of the features of the current agenda on health sector reform that is disseminated internationally.<sup>27–38</sup>

The new system separates and differentiates its functions into regulation (modulation), financing, articulation and provision of services. The health reform introduces structured competition using market forces as the means of achieving public sector goals and generating an appropriate environment for private sector participation. The health reform creates two types of affiliation. The contributory regime is intended for those who are able to pay and who are either employed in the formal sector (for whom two-thirds of the contribution will be paid by their employers), or are self-employed and earn at least the equivalent of double the minimum wage (and pay 12% of their income). The subsidized regime is for those who are deemed unable to pay; it is financed mainly by the general national budget and receives 1% from the contributory regime.

The health care system, which was originally structured to subsidize supply, was reorganized to subsidize demand, enabling health care users to move from one provider to another. By introducing greater choice and competition among public and private insurance companies and providers, the reform attempts to improve quality and efficiency. In this context, the views of consumers on service provision and their choices are believed to be of crucial importance for the optimum functioning of the health system as a marketplace. As one policymaker summarized, ‘users are now the engine and quality regulators of this sector’.

The assumption behind the reform was that strengthening a variety of democratic measures in the health system in Colombia would balance bureaucratic, professional and administrative controls as well as reduce the abuse of power, inefficiency and corruption, and improve the quality of public service delivery.<sup>39–41</sup> Local fiscal choice provides theoretical foundation for the above policies. Local governments raise most of their revenues on their own from local taxpayers. Public sector decision-making then has to deal with the realities of budget constraints. This places special importance on local institutions whose function, among others, is to collect citizens’ expressions of service demands and hold local government responsible for satisfying them. In theory this model works when multiple and independent channels of expression are present.

Participation in Colombia is thus conceived within a new political, economic and legislative framework, in which citizens are entitled to influence issues of public interest through

the exercise of rights and duties in the process of health services and programme management. Colombian health care reforms provide the opportunity for people to participate individually or collectively as citizens and consumers (i.e. they can exercise ‘voice’ and ‘exit’ options). Both forms of participation are put into practice by means of setting up an institutional framework characterized by an open system and welfare rights. According to the legislation, users can now participate either collectively, through user associations, oversight committees, community health committees, and elected community representatives in local administrative boards, or individually, through customer service offices.<sup>42</sup>

The study focuses on two institutional mechanisms created by the state to channel citizen participation into the health sector, i.e. user associations and customer service offices. According to the legislation, the customer service office is a complaint mechanism, which, in theory, should contribute to and enable the decision-making process among providers, insurers and users, building up adequate means for protecting and promoting user rights and health care quality improvements. Likewise, user associations are intended to represent user interests through monitoring health service quality and mediating between insurers/providers and users when user entitlements have been undermined. By law, these mechanisms should be in place in both insurer and provider organizations regardless of their legal status (private or public).

This paper concentrates on the social representations of different actors (policymakers, civil servants, user associations and users) that may hinder or enable effective implementation of participatory policy. The concept of social representation is used here to refer not simply to systems of knowledge and belief that are held by different members of society, but also to systems that are socially constructed and communicated.<sup>43–45</sup> The analysis considers that the position of different actors in the policy arena, the relevance they attach to the issue under study, and their interests, may hinder or enable policy implementation.<sup>30,46</sup>

The study was conducted in a health district with 280 000 inhabitants in Cali, Colombia, a city of 2 million people. This site was selected for various reasons. First, it has a variety of private and public insurance companies and health care providers at all levels of health care delivery. Secondly, it has a high rate of coverage from contributory and subsidized affiliation. And thirdly, its population is representative of different socioeconomic strata.

## Methodology

This case study, with multiple sources of evidence,<sup>47,48</sup> uses a combination of quantitative and qualitative social science methods. It is concerned with social representations that reflect the interactions among the different actors and institutions at various levels of the health system in Colombia. A selected set of informants was chosen from the different bodies operating at different levels of territorial administration, such as the Ministry of Health at central level and the health secretariats at departmental (state) and municipal levels. A group of selected insurance and provider

organizations, which work within the limits of a health district in Cali, were selected along with the population living in this administrative area. The techniques employed are shown in Table 1.

### Qualitative methods

#### *Group discussions*

All groups were users who represented low socioeconomic strata based on classification by the Municipal Planning Department in Cali. They were recruited from various neighbourhoods within the study area. Each group was divided into three sub-groups according to age (18–30, 31–50 and over 51 years) with a balance in sex distribution within each group. Users were defined as participants who had used one health facility at least in the 6 months prior to the group discussion.

#### *Semi-structured interviews*

Semi-structured interviews were conducted to explore the social representations. Selection of informants at different levels of the health system was purposive and included policymakers, government officials, managers from both public and private insurance companies, and health services providers, as well as consumer group representatives from the study area.

### Quantitative methods

A structured questionnaire, designed on the basis of preliminary qualitative analysis, was applied between August and September 1998. A probabilistic multi-stage stratified sample was designed, the sample frame including six strata from different socioeconomic levels as classified by the Cali Municipal Planning Department. To make the strata more manageable, they were divided into three levels: low level, which included strata 1 and 2; middle level, which included strata 3 and 4; and high level, which included strata 5 and 6. The sample size of 661 subjects was estimated through Epi-Info software (version 6.0) and adjusted to account for non-response and non-participation. The number of subjects to be interviewed per stratum was estimated through random selection of households according to the percentage of population belonging to each stratum.

The data, collected by an interviewer-administered questionnaire, consist of socioeconomic information, perceptions about participation in the health care system, and knowledge about how the system works. Some specific questions were reformulated after a pilot study.

The interface between health care user and health care institution was evaluated according to both individual and collective participation in health care. Individual participation was measured by what subjects believed they could do as individuals to improve health care, i.e. complain. Collective participation was measured by their willingness to participate in an association to improve health care, i.e. participation mediated by groups or associations.

The data were double entered into a computerized database using Epi-Info software (version 6.0) and analyzed using STATA software (version 6.0).

## Results

### Institutional actors

The researchers had difficulty making appointments for interviews with institutional actors. In most cases, managers or directors did not attend the appointments, which caused delays in the process and prevented access to other institutional stakeholders.

The study found similarities as well as conflicting views among government officials and managers over the potential of the new policies and legislation to enhance participation. Analysis of respondents' perceptions revealed a range of practical concerns, which can be summarized as follows.

At the Ministry of Health (central level), there was great enthusiasm about the benefits of the new participatory mechanisms. Most informants agreed that services based on negotiation with the user are more effective and efficient than those which are not. Participatory mechanisms, they argued, allow policymakers, implementers and managers to identify consumer needs. At the same time, they anticipated stumbling blocks to effective involvement of the user in health care decision-making and health system monitoring, mentioning that embedded bureaucratic and professional cultures would

**Table 1.** Techniques employed in data collection

Techniques	Actors	Number
Group discussions	Health care users from both contributory and subsidized regimes, and the non-affiliated.	9
Semi-structured interviews	5 policymakers from the Ministry of Health; 3 key informants from departmental level and 3 from municipal level; 9 informants from health care providers and 8 from insurance organizations from public and private companies; and 6 consumer group representatives.	34
Structured questionnaire	Individual adults (over 18 years old) who had used health care in the previous 6 months.	661

delay effective user involvement. Policymakers felt that modifying this entrenched belief might hinder true partnership between provider and user.

At department level, there was concern about the role of the user in monitoring the system. This type of input from society at large was perceived as a duplication of effort that had already been expended in setting up existing quality control mechanisms. At this level of the health system, leaders showed scepticism with regard to the ability of user capacity to influence decision-making. Given the gap in knowledge between professionals and lay people, they found it difficult to conceive that a user should have a say in technical matters. Therefore, according to these views, participation is limited to complaining or resolving specific grievances rather than influencing policy content or organizational change. As one informant put it “You can participate, he/she can participate, they can participate, but it is I who decides”.

At municipal level, and despite enthusiasm towards user involvement in health care decision-making, respondents felt there was a lack of specific resources for promotion and development of participation in health. They also pointed out that the type of contracting carried out between insurance bodies and providers conditioned and limited the scope of participation. Participation was thus tied to predetermined procedures, i.e. user influence could not go beyond what is legally stipulated. Another issue to emerge was that the state and its agencies have neither the capacity to enforce legislation on participation nor the political willingness to do so.

Private insurance companies and private health care providers have limited information about participatory mechanisms. Neither sees the benefit of involving people in decision-making or as quality controllers. However, the private sector sees benefits in customer service offices. This is an individual participatory mechanism used to monitor the quality of health care provision – users’ complaints are generally taken into account when a contract with a provider is revised.

Health insurers and care providers in the public sector considered that there were not enough financial resources to cover the operating costs of participatory mechanisms nor a specific item in the general budget to support their functioning. In contrast, the customer service offices in the private sector were seen as usually adequately funded to fulfil their role.

Private sector institutions, however, demonstrated a lack of trust and commitment in setting up user associations. They also expressed concern about the ‘politicization’ of these groups and their interference with management decisions. In contrast, public sector informants were more inclined to implement participatory mechanisms – because of legislative imperative rather than a belief in the potential to improve quality.

Respondents at almost all levels argued that a lack of a ‘participatory culture’ is one factor that may affect the sense of ownership by a user of newly created participatory mechanisms. ‘Indolence’ and fear of retaliation from the provider, in

terms of refusing to provide services, were highlighted as factors that deter people from participating.

### **User associations**

Of the institutional sample, only three health providers, exclusively public, had set up user associations. These included a primary level hospital with three user associations: one group a self-created community organization and the other two organized by the institution and based on affiliation criteria, i.e. contributory and subsidized, and also including uninsured people. In addition, there were two public health centres each with two associations. The first centre belonged to the public health services network under the jurisdiction of municipal government; this mainly served uninsured people and users with subsidized insurance. The second centre was part of the former Institute of Social Security, which, both before and after the health reform, exclusively served people with contributory insurance.

In regard to health insurers, only two had user associations. One was a co-operative and the other belonged to the municipal government. For both of them, their affiliates were chiefly people with subsidized entitlements.

User associations, as consumer groups, face stumbling blocks in getting involved in quality control. Representatives of these associations felt that they could not play their role adequately because they lacked clear communication channels with the community they represented, and their election tended to be politicized (in the sense that political parties and other community groups influence the voting process, in which there is usually low participation).

With respect to issues of representation, in neither the policy nor the legislation are there details about the meaning of ‘democratically elected representatives’. Furthermore, the legislation does not address issues concerning proportional representation. The study shows that the majority of those who attended the electoral meeting were entitled to elect representatives. In all cases, the election processes were carried out and legitimized by a minimal fraction of the total users or affiliates.

The user association representatives felt that they had limited knowledge of existing participatory mechanisms and of the health system itself, and therefore could not have an impact on decision-making. The asymmetry of information between consumer representatives on the one hand, and managers, civil servants and health personnel on the other, was mentioned as a key factor. Lack of willingness on the institutional side to interact constructively with the representatives was also referred to as an important issue. This institutional attitude is manifested by not allocating resources for participation. There is thus a shortage of resources for consumer groups to exercise their functions properly.

### **Users**

Recruitment for group discussions proved to be difficult. First, the high level of criminal activity in the selected

neighbourhoods hindered access to people's homes; second, the incentives for attending meetings were not of interest to the participants. Therefore, some sessions were cancelled because of low attendance or an imbalance in sex distribution of participants. Men were the hardest to persuade.

In general, participants in the focus group discussions had limited knowledge of the new institutional participatory mechanisms, and of the entitlements available under the compulsory basic health care package. Most participants with social security coverage, either with subsidized or contributory affiliation, recalled having attended talks on topics related to health care entitlements and participatory mechanisms after the participation issue had been introduced. However, none could actually remember what their health care entitlements were or what information they had been given about participatory mechanisms.

When asked if they knew of any form of participation to improve the quality of health service, informants enrolled in either affiliation or without social security coverage highlighted collective action as the best way to exert pressure on health care personnel. All groups expressed commitment to such values as mutual support, solidarity, working together and helping each other. They considered that protesting and complaining could achieve improvements in public health care. Those enrolled in the subsidized system and those without social security recognized the above actions as a moral right, given that they perceive health care as a government responsibility.

When participants were asked afterwards for their opinion on why people did not participate, those covered under the contributory affiliation argued that lack of interest and apathy prevented people from participating. Those with subsidized affiliation, as well as those without insurance, of all ages stated that resignation and fear of expression were the main reasons why people did not get involved in any participation activity affecting health care. One respondent stated that "People are resigned to receiving any old thing and do nothing to look for alternatives to improve things". Another stated that "People are used to being treated badly and to being abused and do nothing about it". Fear of expressing their views on health care performance was also mentioned: "In Colombia people fear to speak out". They are afraid that health care personnel will retaliate by providing low quality health care or by refusing to attend them personally.

A few respondents stated that politicization of community groups and lack of leadership discourages participation. Another factor mentioned, particularly by those without social security, was distrust of both public institutions and democratic mechanisms. Some thought that decision-makers and health care personnel, particularly in the public sector, might not take participation seriously.

#### **Factors associated with willingness to participate**

Of the 661 people interviewed, 62% were women and 38% were men, with an age range of 18–89 years and an average age of 42 years (median 40). Of the respondents, 13% had no

formal education, 36% had primary education only, 26% had high school education, 8% had technical degrees and the remaining 15% had bachelors degrees or had started post-graduate studies. Forty-two percent belonged to a low socioeconomic level, 21% to a middle level and 36% to a high level.

Regarding participation in the General Health Social Security System, 57% were covered by the contributory system, 14% by the subsidized system and 30% were not covered by insurance; 51% used public health care, 45% used private health care and the rest could not recall the type of health care they had used during the previous 6 months.

Survey participation was higher in the low and middle socioeconomic levels than in the high socioeconomic level. In the former it was easier to establish direct contact with the interviewee and almost all people contacted agreed to participate. People in the higher socioeconomic levels seldom answered the door themselves, and we often needed to use personal contacts to convince people to participate.

Of the respondents, 50% stated that they could do something to improve health care quality, 37% believed that there was nothing they could do and the remaining 13% did not know or simply did not answer the question. Regarding collective participation, 65% expressed an interest in participating in a user association to improve the health care system, 31% were not interested and 4% did not know or did not answer the question.

This survey shows the factors associated with the barriers to, and opportunities for, user participation in the health care system. These factors include: level of information about the new social security system, including the new institutional participatory mechanisms; willingness to participate and perceived ability to affect health care decision-making; belief in the capacity to move from one provider to another; and a sense of ownership by the user of the new health system (Table 2).

Individuals that expressed interest in participation were more likely to hold the following beliefs: that they knew the law; that they could choose where to get health care; that they were part of the system; and that they could influence decisions within the system ( $p < 0.05$ ). The beliefs that were significantly associated with interest in collective participation were that 'they felt part of the system' and that they believed they could influence it (Table 3).

#### **Discussion**

The concept of participation or user involvement has been meaningfully transformed over the last three decades according to changes in the global political economy.<sup>5,20,49</sup> Previously associated with community development approaches, user participation is now considered against a background of more market-oriented reforms.<sup>50–55</sup> Users are increasingly being treated as consumers who make demands and have needs that the health services must strive to meet.<sup>56,57</sup> There is, however, considerable controversy over whether or not consumers are able to make informed judgements about

**Table 2.** Distribution of responses regarding health sector reform and participatory mechanisms

Social representations <sup>a</sup>	n/N <sup>b</sup>	%
Knowledge of the new health care system	123 / 659	18.66
Knowledge of the new participatory mechanisms	59 / 653	9.04
Knowledge of some form of collective participation	61 / 657	9.28
Knowledge of what a user association is	55 / 659	8.35
Knowledge about a person or group that represents user interest	83 / 659	12.59
Knowledge of the existence of custom service offices	334 / 635	52.60
Utilization of this office	57 / 392	14.54
Perceived ability to choose where to get services	486 / 657	73.97
Feelings of being part of the system	489 / 652	75.00
Perceived ability to influence decisions within the system	332 / 659	50.38

<sup>a</sup> These include beliefs, knowledge and feelings.

<sup>b</sup> The denominator includes only those who answer the question (people who did not answer the question were not included).

**Table 3.** Relationship between respondents' beliefs regarding the user's role in the system and interest in individual and collective participation

Knowledge and beliefs regarding the user's role in the system <sup>b</sup>	% endorsing statement <sup>a</sup>							
	All respondents	Of those answering yes to:						
		Individual participation <sup>c</sup>			Collective participation <sup>e</sup>			
		n/N <sup>d</sup>	%	p	n/N	%	p	
"I know the law"	9	42/318	13	0.014	39/420	9	0.883	
"I can choose where to get services"	73	246/319	77	0.000	311/424	73	0.162	
"I am part of the system"	75	257/317	81	0.000	330/418	79	0.022	
"I can influence decisions within the system"	50	198/322	61	0.000	258/425	78	0.000	

<sup>a</sup> Out of the people interviewed, those who answered these questions.

<sup>b</sup> These beliefs are the users' social representations concerning the health care system.

<sup>c</sup> In individual participation, individual actions are channelled through customer service offices.

<sup>d</sup> Denominators vary according to who is endorsing the statement; those who stated they did not know the answer.

<sup>e</sup> In collective participation, actions are channelled through user associations or community groups.

complex technical issues, whether consumers are willing to spend time at meetings and to challenge authorities, and whether the mechanisms in place are appropriate to channel society's preferences.<sup>58,59</sup>

State and social sector reforms in Colombia, it is said, have been largely influenced by neoliberal conceptions of the public as consumer.<sup>60</sup> There is, however, also evidence for the communitarian values associated with participatory democracy.<sup>6,11,41</sup> Thus, conflicting principles underlie participation in Colombia – the study found a disjunction between efforts to strengthen participation and belief in the potential of participation to improve the quality of health services. Overall, the data have shown that health care users do not yet have a meaningful seat around the table of decision-making bodies. Their involvement remains limited to expressing dissatisfaction through complaint channels, but

they are not sufficiently able to influence decisions taken at an earlier point in time. There are five main reasons for this.

First, despite the unprecedented burst of institutional innovation regarding participatory policies and legislation in Colombia, this study has found that, so far, institutional stakeholders are not entirely convinced of the need for participatory mechanisms, nor that such mechanisms can contribute beneficially to the working of the health system. These ambiguous feelings by policymakers and health care managers, towards the feasibility and potential contribution of the user in technical or managerial matters, affect resource allocation to participatory mechanisms.

Secondly, there is uneven implementation of participatory mechanisms between the public and private sectors, despite the law making it compulsory for both insurer and provider

organizations to implement such a system regardless of their legal status (private or public). The study found that there is neither institutional capacity nor willingness to enforce the regulation, and that the existence of a legally created participatory mechanism does not guarantee user participation in decision-making. Kadet<sup>61</sup> and Rodriguez et al.<sup>62</sup> point out that some institutional initiatives create tensions between community and government agendas; communities are forced to adjust to the structural, cognitive and political limits of the prevailing institutional norms.

Thirdly, there is a lack of a feeling of empowerment among health-care user associations. Our findings coincide with issues pointed out by authors such as Oakley,<sup>63</sup> Mosquera,<sup>64,65</sup> Rifkin<sup>66</sup> and Standing,<sup>67</sup> i.e. the persistence of long-standing impediments to user involvement in health services decision-making, and political asymmetry, since the gap in technical competence between user and health worker is too wide to negotiate services. Macdonald<sup>68</sup> and Saint Lamont<sup>69</sup> argued that it would be naïve to imagine that the mere adoption of the concept of participation would remove the obstacles inherent in bureaucratic culture and professional paradigm. The dilemma lies in whether or not it is possible to reconcile the operational logic of technical knowledge with community values and ways of working. The ideal of participation is that those affected by decisions must be involved in making them, thus ensuring that any decisions made are acceptable to those affected by them.

A 1994 World Bank<sup>70</sup> report suggests that, given the technical nature of the health field and the tendency of local elites to capture the participatory mechanism, user input alone cannot be counted on to guide decision-makers in allocating resources in a more efficient and equitable manner. The report points out that experiences in the past have shown that populations often demand inefficient, curative-intensive health care.

There is a strong feeling among users, policymakers and health care managers that community representatives and user associations are highly politicized and lack leadership. Community leaders do not necessarily act in the best interest of the community; they are as likely to represent factional groups or to be bound to powerful interests through which they can capitalize benefits for themselves.<sup>60,64,65,67,71,72</sup>

Fourthly, the people interviewed felt able to affect health care decision-making collectively (through community groups) or individually. Nevertheless, the study shows a lack of actual knowledge among health care users of the new health care system, health entitlements and user associations. This would suggest that, with better communication and information strategies, the user's perceived ability might be translated into active participation. Apart from knowledge and perceived ability to affect changes, attitudes, beliefs and values underpin the effective operation of participatory mechanisms. Apathy, resignation and fear of retaliation, politicization of community leaders and distrust of both public institutions and democratic mechanisms were mentioned in the group discussions as impediments to people's involvement. Issues concerning political culture are not easy to change among

institutional actors and citizens in spite of transformations in the political framework.

The survey also indicated that people know more about customer service offices than about other types of participatory mechanism. More emphasis has been put on this mechanism, particularly in the private sector, given its perceived importance for developing marketing strategy, but people have hardly used these offices. This suggests inconsistency between the feeling of being able to affect changes, knowledge and actual participation.

The new participatory policies and legislation are apparently seen, by national policymakers, as a step towards greater democracy for Colombia, at least in terms of formally recognized goals and principles; they reflect high-level consensus at the Ministry of Health that achievement of good governance is central to the reform agenda. The challenge that remains is how to actually implement these goals and principles into workable institutional mechanisms and realise their potential benefits. The Ministry of Health has made important progress in promoting greater participation, but this has not yet reached the key institutional and social actors.

The global economic reforms and significant advances toward democracy made by many countries have tended to result in an overly optimistic and sometimes euphoric view of community involvement. This study has shown that participation is not a matter of policies and legislation; it is a complex process involving belief, customs, ways of life and power relations.

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