Colombia

Colombia lies in the far northwest of South America and extends for 1,141,748 km^2. The country has plentiful water resources, with the Pacific Ocean hydrographic region and the Amazon and Orinoco river basins that empty into the Caribbean Sea being among the most important. The country is organized as a unitary republic; its administrative divisions include the Capital District—where the capital, Bogotá, is located—32 departments, 1,121 municipios, and indigenous territories, which are recognized as territorial entities whenever they fulfill the legal requirements to qualify as such.

Colombia experienced sustained economic growth between 2000 and 2010. Poverty reduction efforts have contributed modestly in the progress toward the Millennium Development Goal (MDG) targets. Involuntary displacement because of violence is the most important internal migration factor. In addition, the country is experiencing a demographic transition, including a declining birth rate and increased life expectancy, which affects the epidemiological profile. The health system has achieved broad coverage and important infectious diseases, as well as maternal and infant morbidity and mortality, have been brought under considerable control.

Selected basic indicators, Colombia, 2008–2010.

Indicator	Value
Population 2010 (millions)	45.5
Poverty rate (%) (2009)	45.5
Literacy rate (%) (2009)	93.2
Life expectancy at birth (years) (2010)	73.4
General mortality rate (per 1,000 population) (2008)	5.6
Infant mortality rate (per 1,000 live births) (2008)	20.6
Maternal mortality rate (per 100,000 live births) (2009)	72.9
Doctors per 1,000 population (2008)	1.5
Beds per 1,000 population (2009)	1.6
DPT3 immunization coverage (%) (2010)	88.0
Births attended by trained personnel (%) (2008)	98.2

MAIN ACHIEVEMENTS

Health Determinants and Inequalities

In the last decade, basic education—preschool, primary, and secondary—has become available to all. Women have increased their level of schooling and participation in work and politics. Between 2005 and 2009, the percentage of people who were poor declined from 50.3% to 45.5%, although extreme poverty rose from 15.7% to 16.4% in that period. In 2009, the gap between men and women in the workforce narrowed (to a 23.5% difference), as did the gap in monthly income (to 20%).

The Environment and Human Security

As of 2010, reforestation had been achieved on 88% of the acreage set as an MDG target for 2015. Colombia has adhered to the Montreal Protocol and substantially reduced the importation and use of substances that harm the ozone layer. In 2008, 15.2% of dwellings were located in at-risk areas.

Health Conditions and Trends

Between 2006 and 2010, there were important achievements in maternal and infant health and in infectious disease control. The use of modern family planning methods rose, and the adolescent pregnancy rate and the infant mortality rate dropped (the latter to 20.6 per 1,000 live births in 2008).

The decade's most serious dengue fever epidemic occurred in 2010, with 157,152 cases (2.3% of them fatal). There were 110,000 reported malaria cases, but the death rate declined. Onchocerciasis transmission has been interrupted throughout Colombia. The effort against Chagas' disease progressed in terms of controlling vertical transmission and vectors. There were 11,433 tuberculosis cases and 283 new leprosy cases, representing a decline in the incidence of the latter. In 2009, 6,924 cases of HIV/AIDS were reported, but the proportion of HIV-positive blood donors dropped. There were no recorded cholera cases.

Deaths due to homicide have declined, especially among young men. However, deaths and disability from traffic accidents have risen, requiring redoubled efforts in traffic safety education and effective traffic law enforcement.

Health Policies, the Health System, and Social Protection

The General Health and Social Security System (SGSSS) has two plans, one contributory and the other subsidized. Together, the two SGSSS plans cover 91.1% of the population. There are special plans for the 4.6% of the population who belong to the military, the police, the teaching profession, oil companies, and public universities. The remaining 4.3% of the population is not covered by the SGSSS. Enrolling in the system is mandatory and is done through 72 health promotion agencies (EPS), which have offered similar mandatory coverage under both plans since 2008.

Total health expenditure was stable in 2009, at 6.4% of gross domestic product (GDP). Out-of-pocket expenditure as a proportion of private health expenditure has stayed at 50%.

Between 2002 and 2010, 243 public hospitals were modernized and their management was improved, which resulted in greater user satisfaction. In addition, the number of general and ICU beds increased, as did the number of outpatient, dental, and emergency clinics.

Colombia's General Health and Social Security System

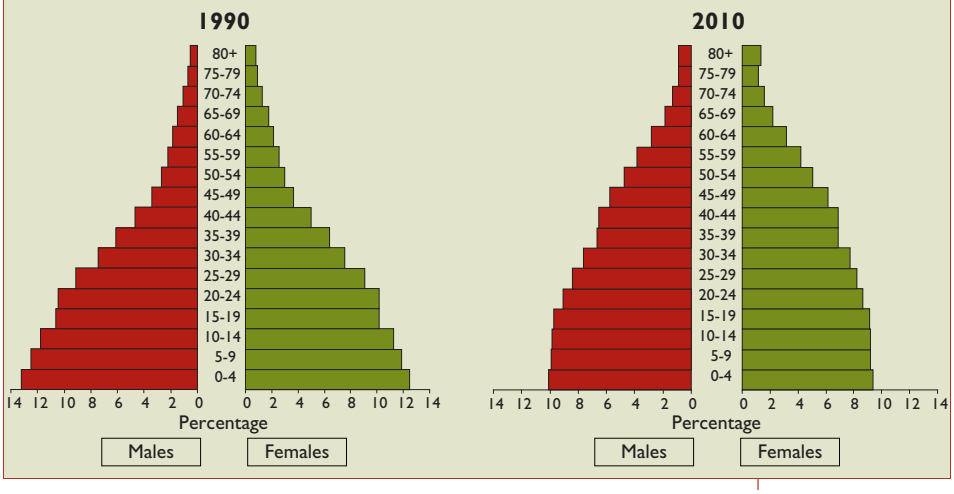
The heart of the health system is the General Health and Social Security System (SGSSS). The SGSSS has two plans: (1) a contributory one, for salaried workers, pensioners, and self-employed workers who earn more than the minimum wage, and (2) a subsidized one, for people unable to pay. The contributory plan requires a contribution of 12.5% of income: the employer puts in 8.5% and the employee 4%; self-employed workers contribute the entire 12.5%. The subsidized plan is financed with subsidies from the contributory plan and funds from the country's general tax revenues.

Belonging to the SGSSS is mandatory. Enrollment is through the health promotion agencies (EPS), which, at a minimum, offer both plans. That has been the case since 2008, when the Constitutional Court ordered the consolidation of the plans in the two regimes.

The SGSSS faces various problems. The base of contributors is low because more than 50% of the population is subsidized. Although the level of insurance is high, practical access to services is very limited in some departments, particularly on the Pacific coast. Each health promotion agency designs its provider network according to market conditions, which may require patients to travel long distances for care or to undergo diagnostic procedures in sites that are far from each other. The law allows for vertical health promotion agency integration, in which the agency has its own providers. However, this contributes to the system's fragmentation.

A Unified Qualification System was established that compels staff and institutions to meet minimum quality standards. The Ministry of Social Protection issued standards to guide the rational use of medicines and medicinal access, quality, safety, and timeliness. In 2010 the National Food and Drug Monitoring Institute was classified as a Level IV national regulatory authority, giving it the status of a reference institution for the Region of the Americas. The year 2006 saw the greatest number yet of newly graduated doctors and nurses.

Population structure, by age and sex, Colombia, 1990 and 2010.



Knowledge, Technology, and Information

Except for telephone landlines, public utilities services increased between 2008 and 2010.

Law No. 1,122 of 2007 set out conditions for consolidating the Integrated Societal Protection Information System, which makes it possible to capture, systematize, and deliver information from the epidemiological surveillance system. In addition, that information system collects and systematizes administrative information so as to monitor health outcomes and buttress the health sector's system of oversight and administration.

MAIN CHALLENGES AND PROSPECTS

Between 2000 and 2010, the economy showed sustained growth, but inequalities persist, as shown by a Gini coefficient of 0.578 in 2009. Unemployment remained stable at 11% between 2006 and 2010. However, women's unemployment rate remains stuck at 6.4% higher than men's.

Educational progress has been notable, but the challenge remains of addressing the low level of literacy and years of schooling among both young people (15 to 24 years old) and women.

Five million people remain involuntarily displaced because of continuing violence. This raises the challenge of meeting their special needs and adapting the health services to give them the greatest possible access to health care.

The displaced population is at risk for vector-, food-, and water-borne disease and for chronic malnutrition. Also among the displaced, pregnant women are at greater risk of becoming sick and of dying. With regard to mental health, displaced persons are more likely to experience depressive disorders, adaptive disorders, and stress.

Colombia is the third most susceptible country in the world for natural

disasters, because most of its population lives in high-risk areas. In 2008, 1.4 million households were sited in at-risk areas.

Unregulated urbanization has increased risks to the poor, with changes in the landscape, biodiversity, air and water quality, waste generation, and the supply of suitable land. Every year large areas are degraded, since 85% of arable land is susceptible to desertification, which affects the agricultural sector's competitiveness and the availability of food and water.

Various ethnic groups comprise 13.8% of the population. Those groups' health situation has not been adequately assessed because it has been difficult to access those communities as well as to harmonize traditional and western medicine.

Vector-, food-, and water-borne diseases, along with respiratory infections and tuberculosis, are important factors in illness and in needed service delivery. However, noncommunicable diseases (including ischemic heart disease, cerebrovascular disease, cancer, homicides, suicides, and motor vehicle accidents) impose the greatest morbidity, mortality, and disability burdens among adolescents and adults. Infectious disease outbreaks will continue as long as unhealthy conditions exist in the homes of the poor and of rural and isolated people.

There has been an increase in morbidity and mortality attributable to noncommunicable diseases, especially cancer, cardiovascular and respiratory illness, and diabetes. Accordingly, health officials have strengthened the programmatic structure and taken steps to promote healthy lifestyles and improve quality of care.

The rate of hypertension in adults was 8.8%; for diabetes, it was 3.5%. Cardiovascular diseases were the leading cause of death in the general population (ischemic disease accounting for 83.7 deaths per 100,000 population, and cerebrovascular disease for 42.6 per 100,000). The second leading cause of death was cancer (stomach, lung, cervix, and breast). Third were injuries (homicides among men, suicides, and traffic accidents). Infectious diseases occupied fourth place.

Of the children under age 5 who die, most succumb to infection. Among adolescents and young adults, homicide, suicide, and traffic accidents predominate. HIV is an important cause of death for men between 20 and 64 years old. In adults (30 to 64 years old) overall, traumatic conditions and cardiovascular diseases share first place. In older adults, chronic, noncommunicable diseases predominate.

The prevalence of overweight in adolescents and young adults increased between 2005 and 2010. A low percentage of hypertensives and diabetics take medicines or receive nutrition or exercise advice.

Although the level of SGSSS insurance coverage is high, practical access to services is very limited in some departments, particularly on the Pacific coast. Each health promotion agency designs its provider network according to market conditions, which may require patients to travel long distances for care. Even though public service coverage increased between 2008 and 2010, in some isolated areas access is still deficient.

Since the year 2000, health care has been monitored through the Registry of Service Delivery to Individuals. Although the registry's quality has improved, information coverage is still limited, since it is basically used to charge for benefits. There is no central entity to coordinate the health information system. This means that the various administrative registries have generated parallel subsystems and incompatible databases, with indicators that are both little standardized and incomplete. Significant underreporting of vital statistics occurs, and deficiencies exist in the registries' quality, processing, analysis, and use of data. Census data are underutilized, as are surveys and other planning and decision-making studies.

Making the health system fairer and strengthening its organization and operation is still a challenge. Personnel, especially medical staff, are concentrated in urban areas, to the detriment of remoter areas or those where armed conflict occurs. Despite the high SGSSS enrollment rate, barriers persist that prevent adequate health care access for rural people, the less educated, indigenous people, and people forcibly displaced.

One of the priority health challenges is the health situation of women, which is characterized by high levels of geographical inequality, adolescent pregnancy, and violence against women. In light of this situation, steps have been taken to strengthen monitoring systems, adopt plans to more quickly reduce maternal morbidity and mortality, and augment the regulatory framework for reducing violence against women.