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THE RECENTRALIZATION OF HEALTH CARE REFORM IN COSTA RICA
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Introduction

Costa Rica's national health care system is widely seen as one of the best in Latin America and serves as a model for other middle-income countries. Whether and how the public system can adjust to the ever-growing needs of Costa Rica's population are therefore issues of importance beyond the country's borders. This paper reports on the health sector reforms of the last several decades, the current return to centralized control, and how these trends relate to the literature on Latin American health care reform.

In Costa Rica, most health insurance policies and services have long been provided by a single public agency, the CCSS. Over the last several decades, the CCSS has constantly reworked strategies for how to cover the entire population with available resources. In the 1970s and 1980s, the CCSS initiated experiments with service models involving the private sector, but always with the institution firmly in control. The 1990s brought a World Bank-backed reform program featuring expanded CCSS primary care, new public management concepts, and decentralization. Thus Costa Rica has sought greater equity and efficiency in its public health sector through a combination of strategies and with mixed results. At the present time, we are witnessing a return to centralized control and public initiative in order to deal with the most pressing health system problems. In as much as the CCSS has traditionally been seen as a paternalistic and hierarchical if also highly effective public institution, there is something of a "back to the future" feel about this return. Compared to regional trends, Costa Rican health authorities have tilted much more heavily toward equity than efficiency concerns and shown relatively weak commitment to neoliberal-inspired reform. While the contracting out of some primary care services caught on, ideas such as internal markets, money following the patient, and decentralization never took root.

The Dominating Role of the CCSS in Costa Rican Health Care

The state dominates health insurance, employment, and provision in Costa Rica via the Caja Costarricense de Seguro Social (Costa Rican Social Security Institute or CCSS). The CCSS also runs the country's public pension program. The CCSS is one of Costa Rica's many semiautonomous institutions, meaning that its budget is separate from that of the central government and its policies are determined by a tripartite board. The board of directors has nine members: three government designees, three from the business chambers, and three representing workers.¹ The CCSS's executive president is appointed by the nation's president and tends to change with each new administration. He or she is a member and chair of the board of directors.

By constitutional mandate, employers, employees, and the state must make payroll social security contributions to the CCSS. For formal sector employees, health insurance quotas are based on an individual's wages and paid by employers (9.25 percent), workers (5.5 percent), and the state (0.25 percent). Self-employed and informal-sector workers pay different rates and are now legally required to contribute to the CCSS, although that has been difficult to achieve in practice. The state pays quotas for indigent persons under a special regime. Adding up all classes of health insurance coverage, the CCSS covers 88 percent of the population (Rodríguez – Herrera, 2006: 44). The 12 percent of the population living without CCSS insurance are thought to be mostly agricultural laborers, informal sector workers, self-employed professionals, and small business owners. Nevertheless, uninsured people do use public health facilities, especially hospitals.²

The CCSS also dominates health care provision. It has 29 hospitals with a total of 5518 beds, compared to 6 hospitals and 261 beds (4.5 percent of the total) for the private sector.³ Most of Costa Rica's doctors work for the CCSS (Clark, 2004: 192). The CCSS also has a sprawling

network of clinics around the country and 940 primary health care teams called EBAIS (see below). Over 44,000 people work for the CCSS (CCSS, 2009). Health sector spending by the CCSS represents 6.3 percent of Costa Rica's GDP.⁴

Early Experiments

In reality, there has never been a point of stasis in the CCSS' attempts to improve the delivery of care, especially primary level services. There has been constant tinkering since the 1970s, when the CCSS began to overtake the Ministry of Health as the largest supplier of health services in the country. The earliest experiment dates back to 1970 when the CCSS approved the first company doctor (*medicina de empresa*) contract. Under this form of primary care, companies agree to pay the salary of a CCSS doctor and provide office space. The CCSS continues to provide all necessary testing and medications. The CCSS gains assistance in paying for the cost of medical services and companies and employees enjoy the benefits of recouping the time a worker might spend waiting on line at a neighborhood clinic. But the program's impact has been limited. Although 1700 businesses currently participate (Solís, 2008), in 2007 it only accounted for 8 percent of the CCSS' total non-emergency outpatient consultations.⁵

In 1980, the CCSS piloted the mixed medicine (*medicina mixta*) model in which patients pay for an office visit to a private physician and the CCSS provides testing and medications. The original goal of the program was to relieve waiting lists in certain specialties. The model remains active but never came to represent an alternative for most people for ideological and practical reasons. The mixed medicine model both offends a strong anti-privatization current within the CCSS and, because it is based on fee-for service payments, is too expensive to expand. In 2007, the mixed medicine model accounted for 3 percent of CCSS non-emergency out-patient consultations.⁶

The experiment that would have long-lasting consequences happened in the late 1980s. As Dr. Guido Miranda, executive president of the CCSS from 1982-1990, recounted to this author, the CCSS' decision to contract out a primary care clinic to a cooperative of health care providers in 1988 was the eventual outcome of President Arias' insistence that the CCSS allow people to see private physicians.⁷ Dr. Miranda looked for a way to do this without privatizing the CCSS. It was critical to Dr. Miranda that the CCSS maintain control over the way private physicians were incorporated. So he chose to experiment with importing the British general practitioner (GP) system, in which primary care physicians handle the population of a certain geographical region, to Costa Rica. This experiment would dovetail with a concurrent CCSS initiative to build a specialist training course in the field of family and community medicine with assistance from McGill University of Canada (Davis, Haggerty, and Filion-Laporte, 1992). There was success in establishing the resident program but the first attempt at setting up a GP system with private physicians in a town outside of San José failed when the doctors would not respect each other's catchment areas.

The doctors needed an incentive system which induced sharing. Dr. Miranda gambled that doctors might be able to work better within the business structure of a cooperative. Cooperatives were already a wide-spread form of worker-owned business in Costa Rica, Miranda asked a group of private physicians to form one and take a contract from the CCSS to provide primary care to a defined geographical region. The CCSS was slowly expanding its coverage by building new clinics and the cooperative group aimed to accept a management contract for one of them in order to not displace CCSS employees from existing facilities. In 1988, Dr. Miranda and his team were able to claim the new clinic in the capital suburb of Pavas for the first cooperative-run facility. Interestingly, the head of the Pavas clinic cooperative, Dr.

Fernando Marín, was simultaneously pushing the medical community to take a more holistic approach to primary care. He was one of the intellectual fathers of the concept of EBAIS, the multidisciplinary health teams which would be built into the national reorganization of primary care discussed below (Marín Rojas, 1992).

After 1988, the CCSS continued to contract out the management of clinics until there were 6, all located in densely populated areas of the San José metropolitan area. Four are run by cooperatives of medical providers, one by a similar association, and one by the University of Costa Rica. The clinic operators are free from public law in terms of purchasing and personnel management. They are responsible for the purchasing of all inputs and, until recently, have been allowed to lease the CCSS facilities they use for free. These clinics serve the same catchment areas that would be assigned to a CCSS facility and must provide the population the same package of services (general and specialized care, emergency care, minor surgery, dentistry, drugs, laboratory tests, radiology, and social work and benefits verification services). They are paid on a capitated basis by the CCSS. These third-party clinics currently serve the primary care needs of over 500,000 people, or close to 12 percent of the population (Díaz, 2009). As we will see below, a 2006 report by the Costa Rican Contraloría (Comptroller's office) revealed contract irregularities and fueled debate over whether the contracted clinics were more or less expensive than regular CCSS facilities. These issues finally forced the CCSS to formalize this "experiment" with contracting out and subject it to a public bidding process.

Official Reforms

In contrast to the experiments above, this section discusses the outcomes of reforms which were officially labeled as such and which were much larger in scale. In 1993, the Costa Rican government signed a \$22 million health sector loan package with the World Bank. It had

three main components: 1) reorganization of the primary care model, 2) separation of the purchaser and provider roles, coupled with deconcentration of considerable authority and responsibility to operating units; and 3) modernization of payment mechanisms. This package effectively represented a compromise between Costa Rican and World Bank officials. Costa Rican health officials were almost exclusively dedicated to solving problems in the primary care system. They had no objections to upgrading payment collection technology. But they agreed to deconcentration only because the actual mechanisms to be used in formalizing purchasing relationships and creating an internal market were left vague in the loan document. World Bank officials tended to think that the amount of care Costa Ricans received was fine. They were far more concerned about the economic efficiency of the system. For that reason, the World Bank focused on hospital finances, as that is where most health spending went, and on maximizing payments through a modernized collection system.

I have given detailed descriptions of the implementation of the reforms and the view of CCSS doctors and their interest organizations toward them in two articles (Clark, 2004, 2005). Here I will summarize what was and was not accomplished. The stand-out accomplishment of the Costa Rican health reform has been the enhancement of primary care, especially in the sense of adding resources to clinics serving marginal rural and urban populations. Costa Rican health officials carried out the plan they proposed to the World Bank almost 20 years ago: to reorganize primary care so that services would be spread more equally across the country and represent a comprehensive or integral form of health care as opposed to a purely curative one. This was done with the formation of health care teams called EBAIS (Equipos Básicos de Atención Integral de Salud). EBAIS are distributed on a capitation basis and include, minimally, a medical doctor, a nurse, and a technician. They are able to draw on the other personnel located

in the CCSS health area to which they belong. These personnel include laboratory technicians, social workers, dentists, nutritionists, and pharmacists.

The EBAIS model was rolled out in 1995, starting in the farthest-flung rural locales and moving in toward the capital. Virtually the entire country was covered within 10 years. There are currently 940 EBAIS covering an average of 4505 inhabitants each (Montoya Solís, 2007). The instant popularity of the EBAIS helped maintain the momentum for expansion even after the original reform team had been replaced. Every community wanted one. For many clinics, the new model simply meant relabeling existing staff to a new organizational scheme. But in underserved areas, EBAIS meant new health posts, new resources, and better access (EBAIS are mobile where needed in rural areas). While the EBAIS were being installed, the CCSS increased the budget allotted to the first level of care in absolute terms as well as relative to spending on hospitals. Localities which had been under funded also received larger per capita budget increases for primary care and that helped to smooth out geographical inequities.

Another success of the reform program, albeit a smaller and less complicated one, was the CCSS' installation of a vastly upgraded collections system, SICERE (Sistema Centralizado de Recuadación or Centralized Collections System) in 2001. SICERE fully automated the monthly collection of pension and health quotas from employers and workers. The World Bank had pushed for this modernization of the CCSS' collection system as a technical solution to the need for a faster, less cumbersome way to transact and trace social security payments, thereby reducing evasion. Though SICERE benefitted both sides of the CCSS, health and pensions, it was motivated more by the need to complement the concurrent creation of a new, obligatory private pension pillar.

Where the reforms fell far short of intended outcomes was in the area of creating incentives for budgetary efficiency. Originally thought of as an internal market-like plan of separating the purchasing and the provision of health services within the CCSS, this portion of the reforms was eventually re-labeled as administrative deconcentration. This part of the plan got off to a slow start because the Costa Rican reformers were disinterested and inexperienced in it and because the World Bank agreement lacked details about what exactly was to be done. The original internal market idea floated by the reform team involved CCSS hospitals competing for the “business” of clinic patients, and would have required the ability to track referrals and operate a semi-retrospective budget. Given the gap between the CCSS’ information systems and what would be required, the potential for massive service disruption, and probable backlash from operating units, the internal market model was quickly rejected.

A 1997 CCSS publication, *Hacia un nuevo sistema de asignación de recursos*, described the reform team’s scaled back plan for giving operating units, starting with hospitals, incentives to meet production and quality goals agreed upon annually. Operating units would receive 90 percent of their normal budgets up front, with 10 percent withheld as an incentive to live up the conditions laid out in a performance contract (*compromiso de gestión*). But this plan too was unacceptably controversial and the incentive scheme had to be softened. In addition, opposition from CCSS workers’ unions and professional associations obstructed early plans to grant hospital directors substantial autonomy over personnel decisions. Hiring and firing remained the responsibility of central CCSS authorities.

Performance contracts were finally piloted in the seven national hospitals in 1997 and had spread to all CCSS operating units by the early 2000s. By that time, the process was more fittingly called deconcentration, indicating that it was one of administrative devolution, not full-

scale decentralization. Units scoring at or above 85 out of 100 on their annual review receive a bonus of 2 percent of their budget. Those scoring below 85 (a rarity) are not penalized. The hospital directors I interviewed were very pleased with what little autonomy they did gain from deconcentration (mostly in the area of purchasing). And the performance contracts may have made hospital and clinic directors pay more attention to the relationship between budgets and outputs. But, as the World Bank says of its own reform, deconcentration did not succeed in linking payments to performance and had little impact on waiting lists or hospital inefficiency (2003:25).

Rodolfo Piza, executive director of the CCSS under the Miguel Ángel Rodríguez administration (1998-2002), added his own twist to deconcentration, one not envisioned by the authors of the original loan agreement. The new addition was elected citizen health committees called *juntas de salud*. Piza and his team were inspired by regional trends toward political decentralization and thought that the *juntas* would bring citizen oversight to their local CCSS facilities (Clark, 2004:208). Starting in 1999, the *juntas* have been elected every two years by citizens who are directly insured by the CCSS or who were when they retired. There is one *junta* for every hospital and larger clinic in the country. The *juntas* are 7-member boards composed of 3 citizens insured by the CCSS, 2 from employers associations, and 2 from health-oriented community organizations. The employers choose their representatives while the other members are elected by citizens. The original idea was that the *juntas* would balance the power of the CCSS authorities through direct involvement in areas such as drafting performance contracts, selecting hospital directors, and executing the budget, but they have been downgraded over time to the auxiliary role of assisting officials in carrying out public health campaigns.

By 2004, the deconcentration process had come to a standstill. In that year, the CCSS was hit with the largest corruption scandal in its history and the executive president and other high-ranking officials had to resign. After those resignations, the CCSS went through two more executive presidents before Eduardo Doryan helped the institution regain stability during his tenure (2006-2010). However, Doryan was not interested in deconcentration and instead focused on other fixes to different institutional problems. Deconcentration still officially exists and performance contracts are signed every year, but the model is not being pushed further nor is it seen as a useful tool for improving managerial efficiency. The 139 *juntas de salud* also continue to be elected but they are plagued by disinterest. In the last elections for them in 2009, only 15,000 people voted out of an eligible 1.7 million.⁸

What Now? Recentralization

Since 2006, the CCSS has focused on several problems and all of these efforts have involved (re)taking up the reins of direction and investment from the central offices of the institution. There is no visible ideology behind this centralization other than the implicit decision to work within existing institutional structures rather than opt for privatization. The measures taken in the last four years make up a pragmatic response to pressing problems. This focus is clearest in the areas of bringing efficiency gains to the supply chain, investment in infrastructure, and waiting lists. The CCSS has also been pressured to better regulate the contracts to third parties providing primary care services, something that reinforces the trend toward stronger central control.

The new importance given to improving the functioning of the chain of supply and to infrastructural investment can be seen in the establishment of dedicated offices within the CCSS.

Administratively, there are 6 offices within the CCSS, 1 for pensions and the other 5 focused almost entirely on health. Most of the institution's energies are committed to the health side rather than pensions because of the greater complexity of providing health services to the entire population. In 2008, what was formerly known as the Office of Operations was abolished and split into the Office of Logistics and the Office of Infrastructure and Technology. The Office of Logistics exists to oversee every aspect of the supply chain. The purview of the Office of Infrastructure and Technology is to manage the investment in physical infrastructure and maintenance of such. Waiting lists are overseen by the Unidad Técnica de Listas de Espera (the Waiting Lists Unit or UTLE), which is part of the Medical Office. UTLE was created in 2004 but its work came to have greater importance and visibility after 2006.

The Supply Chain

Given the CCSS's dominance in the provision of medical services, guaranteeing the supply of the necessary inputs is of great importance. The supply chain includes medications, medical instruments, eyeglasses, medical apparel, and hospital linens. The CCSS' own factories produce eyeglasses, medical apparel, linens, and some medications. The 19 different drugs plus IV fluids manufactured by the CCSS add up to about 8 percent of the medications the system uses.⁹ All other pharmaceuticals are imported, as are almost all medical instruments. The institution launders all medical apparel and hospital linens itself. There are several points in the supply chain where improvements could be made, but the storage of medications has long been seen as *the* problem. In particular, the CCSS supply chain long had the aggravating ability to simultaneously allow some medicines to run out in its facilities but store others past their expiration dates and in conditions which damaged them. The Logistics Office targeted this and other problems when it launched the Proyecto de Modernización de la Cadena de

Abastecimiento (Project for the Modernization of the Supply Chain) in 2008. Using improved computer technologies and contracting processes as well as investment in a few key spots such as expanding the domestic production of inter-venous fluids, the CCSS Office of Logistics has made considerable gains. For example, the average number of out-of-stock medications has dropped from 38 (in 2005-2007) to 6 (in 2008-2010). By achieving a faster turn-over of stocks, having to discard and replace fewer medications, and reducing the importation of medical fluids, the CCSS is maintaining a larger supply of inputs for the same expenditure, which is a net savings. With this savings, the institution has been able to purchase more name-brand drugs, especially the newer, more expensive treatments for cancers and HIV/AIDS.¹⁰

New Building

The amount of new building in the last 4 years has also been impressive. The Doryan administration recognized an infrastructure deficit, that is, a gap between population growth and aging facilities requiring new or remodeled building. The Infrastructure and Technology Office began on a strategy to close the gap. Between 2006-2009, the CCSS nearly quintupled such investment.¹¹ Since 2006, the CCSS has built 2 new regional hospitals (in Heredia and Osa), remolded a national hospital (Raul Blanco Cervantes), and built new towers for Women's Hospital in San José and the regional hospital in Liberia. It has also built 5 new intermediate-level facilities called Centros de Atención Integral en Salud (Centers for Integral Health Attention or CAIS).¹² CAIS offer specialist consultations, round-the-clock emergency rooms, normal labor and delivery services (with inpatient beds), and outpatient surgery. The idea is to offer some hospital services in places not already served by a hospital. The Infrastructure Office is about to build another new regional hospital in Golfito as well as new facilities for the main laundry and laboratories in San José. Although some of this building has been done with loans

from the Central American Bank of Economic Integration, CCSS officials say they are really self-funded. The central government is typically in arrears on the quotas it owes the CCSS (0.25 percent of salary per worker plus 9.25 percent for its own employees). So what is sometimes done is that the government takes out a health-sector loan from a multilateral bank and the Ministry of Finance repays it, thereby cancelling its debt to the CCSS.

Waiting Lists

The reform unit that has not performed as well as the other two is UTLE, where officials are trying to reduce the waiting lists. UTLE was created before 2006 as waiting lists have long been a problem, but it was reinvigorated after a January 2006 constitutional court (Sala IV) decision that Costa Ricans' right to health services required the CCSS to reduce waiting lists (Program Estado de la Nación, 2007:90). A person is officially on a waiting list when his or her appointment is set for over 90 days into the future. There are three categories of waiting lists: surgery, diagnostic procedures, and specialist consultations. Of course, they are interrelated, as one often leads to a referral to the next. And there are multiple causes for waiting lists. On the demand side, there is population growth and aging as well as the ever increasing variety of interventions made possible by new medical technology. On the supply side, relative shortfalls of physical infrastructure, equipment, and qualified personnel contribute to the problem. Besides general surgery, the specialties with the worst waiting lists are radiology, cardiology, ophthalmology, orthopedics, and gastroenterology.

In addition, behaviors on the part of doctors and patients aggravate the problem. Patients sometimes manage to subvert rather lax catchment-area residency rules and get on more than one waiting list for the same procedure. They can and do appeal to Costa Rica's constitutional court for intervention. UTLE's director says that the CCSS is often directed by the Sala IV to

accommodate a waitlisted person immediately and hospital administrators dare not ignore the order.¹³ The Sala IV is reportedly handling 60 such cases a week (Mata, 2009). Meanwhile, specialists manage their own waiting lists with the result that they sometimes succumb to appeals for favored treatment, side payments, or just sub-optimal decision making in terms of gauging how quickly each patient needs to be seen. Because each CCSS hospital uses a unique computer system, the lists are not centralized and therefore cannot be managed from headquarters.

CCSS central authorities have addressed the problem directly and indirectly. For 18 months in 2008-2009, the CCSS invested in pilot projects to see if adding extra hours and budget to key areas would reduce waiting lists. They paid surgeons extra to do additional operations in all areas, but especially ophthalmology, after their regular 7:00am – 3:00pm shifts. They also paid for extra manpower to speed up the evaluation of biopsies. These programs stopped, as scheduled, at the end of December 2009. Another program to pay for extra manpower to conduct and interpret ultrasounds and mammograms is on-going. UTLE has been evaluating the phased-out programs in order to make adjustments before the next round, planned for implementation sometime during July-December 2010. CCSS data show that there was a dip in all three types of waiting lists in the last quarter of the pilot programs, but that they rebounded as soon as the programs were halted (CCSS, 2010). UTLE authorities have also noticed cases of surgeons shifting regular morning operative patients to later slots to take advantage of the higher after-hours piece rate of pay. There was also a problem of doctors taking cases out of order from the waiting queue. UTLE has learned that it must monitor the programs closely to make sure that regular shift productivity does not drop off and that cases are taken in order of the existing waiting list. UTLE is also in the process of reducing the authority of individual specialists to handle waiting lists. UTLE plans to instruct each hospital to form a team which will be

responsible for developing a system to deal with its waiting lists and submit it to the CCSS' board of directors for approval.

Indirectly, the CCSS has been trying to solve the waiting list problem as well as increase the volume of services overall by training additional specialists. As reported in Clark 2005, at the turn of the century, the Colegio de Médicos y Cirujanos (College of Physicians and Surgeons), and the 2 unions representing CCSS doctors, the Unión Médica Nacional (National Medical Union), and the Sindicato de Profesionales en Ciencias Médicas de la CCSS e Instituciones Afines (Union of Medical Science Professionals of the CCSS and Related Institutions or SIPROCIMECA) successfully lobbied the CCSS to open more residency spots. In Costa Rica, only specialists, as opposed to generalists, receive residency training and only CCSS institutions provide it. This means that the only way to train more specialists in the country is to convince the CCSS, specifically the Medical Office, to open more spots. In 2004, all of these parties signed an agreement to gradually increase the number of residency spots from 350 to the current 700.

For the first five years, the CCSS managed to extract a high price for these opportunities by requiring new residents to sign the *contrato de aprendizaje* (traineeship contract). Residents thereby promised that, upon completion of their training, they would serve 3 years for each 1 year of residency anywhere in the country the CCSS needed them. Thus newly minted residents were required to serve a minimum of 9 years wherever the CCSS sent them or pay a fee of 32 million colones (approximately \$75,000) to be released of this commitment. The CCSS was very pleased with the guaranteed future stream of specialists this agreement would provide them but residents thought it overbearing. In June 2010, with the support of the Unión Médica and the Sindicato Nacional de Médicos Especialistas (National Union of Medical Specialists or

SINAME), the residents went on strike over the single demand that the CCSS abandon the traineeship contract. The 13-day strike resulted in a compromise. The CCSS lowered the requirement that graduated specialists go to work anywhere in the country they are needed from 3 years per year of residency to 1 year per year of training. And instead of having to personally pay to be released of the obligation, all residents will have to contribute 8 percent of their base salary annually to a fund. The fund would then have to pay a penalty to the CCSS should the resident opt out of the agreement. If the resident honors the *contrato de aprendizaje* at the end of the training period instead of opting out, he or she will be paid back the contributions made to the fund. The new rules weaken the incentives for newly-minted specialists to leave the greater San José metropolitan area substantially.

Third Party Provision of Primary Care

Finally, while contracting out primary care to non-CCSS providers might be seen as a form of decentralization, changes implemented since irregularities were publically exposed in 2006 can be seen as a reassertion of centralized institutional control over the matter. These contracts have caused two types of controversy. The first is over whether data show that non-CCSS clinics are more or less expensive than CCSS-run clinics. On the one hand, the CCSS' position has been that, on a per capita basis, the contracted clinics cost slightly less to run than its own. At least one published study supports that view. Using data collected in 1990-99, Guari, Cercone, and Briceño (2004) found that the contracted clinics' real total per capita expenditure was lower than in traditional clinics and that this was not done by turning away new patients, refusing emergency cases, or substituting nurses for doctors. Instead, the contracted clinics tended to rely on a higher percentage of primary versus specialist care, authorized fewer sick days, did fewer laboratory tests, and dispensed fewer medications than traditional clinics. On the

other hand, the Contraloría General de la República studied data on all 6 clinics for the period 2000-2006 and found that their costs were greater on average than for the same services the CCSS provided in its own clinics (4 were more expensive than the CCSS and 2 cheaper). The second controversy is over what else the Contraloría found. It found that the CCSS had violated Costa Rican law governing public institutions by not using an open bidding process to select contractees. According to the Contraloría, the CCSS did this in the face of repeated warnings from it as well as internal legal advisors. Furthermore, the CCSS violated the law by not charging rent for the use of its facilities and granted extra resources to the contractees in the form of free equipment and “incentive” payments (Contraloría General de la República, 2006; Feigenblatt, 2006a, 2006b).

Since the Contraloría’s findings became public, the CCSS has been forced to design a competitive bidding process for the contracts to run the outsourced clinics in metropolitan San José. New contracts were awarded in 2010. The same organizations won the contracts, although CCSS officials say there was significant competition.¹⁴ These organizations include 4 cooperatives (Coopesalud, Coopesain, Coopesiba, and Coopesana), 1 for-profit doctor’s group, Asociación de Servicios Médicos Costarricenses (Association of Costa Rican Medical Services or ASEMECO), and the University of Costa Rica Medical School. In preparation for the new contracts, the CCSS had to develop a methodology to determine appropriate costs for the outsourced clinics. The providing organizations will be on 5-year renewable contracts and the CCSS’ board of directors is obligated to review their performance every year. This increased scrutiny makes it more likely that the third parties will be held to their agreements this time around. CCSS officials are also concerned that the cooperatives obey the legal requirements for cooperative status, namely that all employees be registered as owners, not just a few as was the

case in at least one instance. And clearly, the Contraloría will now enforce a stronger regulatory role over the CCSS' outsourcing.

Although these contracts affect a sizable portion of Costa Rica's population, labor unions have not been able to challenge the most significant form of privatization the CCSS has seen. CCSS officials stress that, after more than 20 years with these groups managing a number of clinics with their own employees, the public sector could not easily supply the manpower needed to run them were the contracts disallowed. Nullifying the contracts would likely cause a serious disruption in services, something no party wants to be responsible for.

Fit with Literature on Latin American Health Sector Reform

So how does the Costa Rican case fit with trends in Latin American health care reform? What is impressive about the last three decades of health care reform in Costa Rica is the lack of interest in radical reorganization, the absence of commitment to extensive decentralization or ideas such as money following the patient, and the general agreement that it is the CCSS' responsibility to provide health services to the majority of the population. In other words, Costa Rica has shown weak interest in neoliberal-inspired reform. The only real example of separating the purchaser and provider and working with private sector entities is the contracting out of capital-area primary care facilities. And there are no plans to extend this model. CCSS officials are uncomfortable talking about contracting out. So Costa Rica does not conform to the picture painted by Katie Willis and Sorayya Khan in which health reform in all Latin American countries save Cuba fits with a neoliberal agenda (2009: 996). Costa Rica's is better described as one of Latin America's several hybrid approaches to seeking both equity and efficiency in health care (Lakin, 2010: 314). In comparison to Chile, for example, Núria Homedes and Antonio Ugalde find that Costa Rica's involvement of the private sector in the national health

care system has been more limited, home grown, and pragmatic and that it has resulted in greater equity and efficiency (2002:60). Joan Nelson argues that Costa Rica's World Bank-backed reforms tilted much further toward equity compared to other contemporary regional examples (2004: 48). Indeed, while deconcentration failed, the expansion of primary care services through EBAIS can be considered a success.

Compared to other regional examples on the extent of decentralization in health care, Costa Rica is again notable for the lack of radical change. This fact also affects our understanding of the current trend toward recentralization. In countries where health sector decentralization has gone much further, such as Brazil, recentralization can be understood as a reaction to its tempo, sequencing, and/or outcomes (Gomez, 2008). But Costa Rica's deconcentration did not go very far, and the recentralization discussed above was, for the most part, not a reaction to its failures. Although the creation of an internal market might have brought efficiency gains, no one in Costa Rica is arguing that the failure to pursue deeper decentralization is responsible for the problems currently under focus. Rather, what we are seeing is better understood as a refocusing on problems that happen to require action from authorities at headquarters. They call for manipulation of a national-level purchasing system, large infrastructural investments, and routinized, transparent oversight by officials who can be held accountable to the board of directors. The rejection of local control also represents a retreat toward traditional patterns of hierarchical administration. As Lynn Morgan demonstrates (1993), the CCSS has long been notorious for its paternalism and distaste for community participation. More recently, the World Bank reported that its efforts to promote decentralization within the institution had been undermined by internal opposition (World Bank, 2003: 11).

Conclusion

The long-term dominance of Costa Rica's centralized state health care system, rejection of radical or neo-liberal reform, and dependable focus on equity goals makes it an outlier compared to other Latin American models except for Cuba. The private medical sector has not been excluded entirely from the reforms discussed here but always kept under the firm control of the CCSS. New public management concepts have yet to take root in the CCSS. Future research could fruitfully focus on at least two areas. The first is whether the current improvement programs do enough to help the CCSS meet the growing demands of the Costa Rican population. It is not at all clear, for example, whether the CCSS can reduce waiting lists to more acceptable levels. The second issue is the extent to which Costa Rica may be facing a trend toward passive privatization in medical insurance and services. The recent opening of the state insurance monopoly, a jump in the use of private medical services particularly among upper income deciles, and expansion of private hospital groups all point toward this possibility.

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¹ Of the worker representatives, one is chosen from the labor unions, one from the cooperative sector, and one from *solidarista* (company union) employees' groups.

² Cercone, Durán, and Briceño (2001:47). Hospitals are supposed to charge uninsured people for services but they do not always do it. In addition, the CCSS imposes no rule about how long a person must pay into the system in order to be fully covered. This gives incentive to on-again, off-again membership whereby some people only pay quotas when they have a significant health problem and then stop payment after treatment is received.

³ Data from CCSS, 2009 and interview with Dr. Edgar Cabezas, CIMA San José Hospital, San José, June 2, 2010.

⁴ Rodríguez-Herrera (2006:55). Figure is for 2003.

⁵ Author's calculations from data available on the CCSS website, Gerencia Médica, Estadística de Salud: Estadística año 2007, cuadro no. 3, accessed at: http://www.ccss.sa.cr/html/organizacion/gestion/gerencias/medica/dis/dep_estadistica/des/publicaciones/estadisticas/2007/pdf/ac07.pdf

⁶ Author's calculations from data available on the CCSS website, Gerencia Médica, Estadística de Salud: Estadística año 2007, cuadro no. 3, accessed at:

http://www.ccss.sa.cr/html/organizacion/gestion/gerencias/medica/dis/dep_estadistica/des/publicaciones/estadisticas/2007/pdf/ac07.pdf

⁷ Interview with Dr. Guido Miranda, San José, Costa Rica, June 11, 2010.

⁸ Figure represents number of people directly insured plus those formerly directly insured, now retired, for 2008. From CCCS, 2009. Voting figure from Villegas, 2009.

⁹ Interview with Claudio Arce, Gerencia de Logística, CCSS, San José, June 7, 2010.

¹⁰ All outcomes data from: CCSS, Gerencia Logística, “Resultados de la Gestión de la Cadena de Abastecimiento,” internal report, San José, May 2010.

¹¹ Spending increased from 12,617 million colones in 2006 to 61,774 million colones in 2009. Data from interview with Gabriela Murillo, Manager, Office of Office of Infrastructure and Technology. CCSS, San José, Costa Rica, July 11, 2010.

¹² Located in Puriscal, Siquirres, Desamparados, Cañas, and Buenos Aires.

¹³ Interview with Dr. Gerardo Arias, Coordinator of UTLE, CCSS, San José, June 10, 2010.

¹⁴ Interview with Jorge Arturo Castañeda, CCSS Internal Auditor, San José, June 8, 2010.

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