

HEALTH SECTOR REFORM IN COSTA RICA: REINFORCING A PUBLIC SYSTEM

Mary A. Clark
Tulane University

Prepared for the Woodrow Wilson Center Workshops
on the Politics of Education and Health Reforms
Washington D.C.
April 18-19, 2002

Introduction

The Costa Rican health sector is dominated by the state. A single public institution monopolizes health insurance and provides most of the curative and preventative services available in the country. The health sector reforms of the 1990s are unusual among Latin American cases because Costa Rican authorities rejected key aspects of the regional reform agenda, such as privatization and decentralization. Instead, Costa Rican health reforms have sought to improve the public system by completely overhauling the primary care network and deconcentrating administrative responsibility.

This paper traces the political process of health sector reform in Costa Rica. After a summary of the history and organization of the sector as well as the major problems it faced on the eve of reform, the paper maps the evolution of the health reforms begun in the 1990s. The description begins with the reform program's intellectual origins and negotiation with the World Bank and continues through two stages of implementation. Four important themes emerge from the Costa Rican "story."

First, the health reforms reflect a mix of priorities dating from the original negotiations between the Costa Rican government and the World Bank. While the Costa Ricans were concerned to restructure primary care and steer more resources toward that level, World Bank representatives pushed for the separation of the purchasing and providing functions within the public system as well as other institutional modifications. Second, we can see the importance of "change teams" in directing the health reforms toward particular goals. The turnover of political appointments resulting from the change of government in 1998 led to the substitution of one change team and its priorities by another. Third, the actual degree of independent decisionmaking for operating units under deconcentration has been quite limited. Fourth, the Costa Rican reforms have combined rapid and gradual implementation along with extensive consultation and negotiation with stakeholders. The last section will outline some preliminary conclusions about this mix.

The Costa Rican Health Sector

The state dominates health insurance, employment, and provision in Costa Rica. The CCSS (Caja Costarricense de Seguro Social or Costa Rican Social Security Fund), a public institution, virtually monopolizes the domestic health insurance market as well as administering the national pension system. The CCSS also provides most of the country's curative services via 240 clinics, 29 hospitals, and 5924 beds.¹ Membership in and financing for the public health insurance system are employment based. For formal sector employees, membership is mandatory and quotas are based on an individual's wages and paid by employers (9.25%), workers (5.5%) and the state (0.25%). Self-employed and informal-sector workers are encouraged to join the CCSS' voluntary plans. Such workers pay between 5.75 and 13.75 percent of their salaries for health insurance, depending on income. The CCSS' health insurance programs enroll 67 percent of the economically active population and 89 percent of the total population. The latter figure includes workers' dependents as well as indigent persons provided free care under special regimes. Thus slightly more than 10 percent of the population, composed of agricultural laborers, informal sector workers, self-employed professionals, and business owners, lives without public health insurance.² Nevertheless, uninsured people do use public health facilities, especially hospitals.³

While over 90 percent of Costa Rican doctors work for the state, a third of them also have private practices and there are six small private hospitals with a total of 196 beds.⁴ Payments for private health goods and services, mostly medicines, dentistry, and office visits, account for 26% of total health spending.⁵ Hospitalization and insurance account for only four percent of private health expenditures.⁶ A very small number of people, mostly executives and professional staff of multinational corporations, carry foreign insurance policies. In addition, the state insurance institute INS (Instituto Nacional de Seguros) sells private, domestic medical insurance policies but these account for less than one percent of private health spending.⁷ It is illegal for private, domestic companies to sell medical insurance directly.

Before the CCSS initiated public health insurance in 1942, citizens had to pay for health care out-of-pocket, work for a company that had its own doctor, or beseech the few charity clinics. President Rafael Angel Calderón Guardia (1940-44), a medical doctor, took a personal interest in establishing a social security system in Costa Rica and his administration drafted the legislation creating the CCSS. The CCSS began by extending health coverage to low-paid urban wage workers. Coverage progressed very slowly as the CCSS' mandate only extended to workers below a certain salary cap and the institution suffered chronic financial instability due to the state's inability to pay its contributions.⁸ This should have changed after 1961 when the legislature amended the constitution and mandated the CCSS to "universalize" coverage in health and pensions. Coverage for health services did increase from 17 percent of the total population in 1961 to 46 percent in 1970,⁹ but the newly insured were mainly family members of previously enrolled workers (vertical extension). Mandatory enrollment was still limited by a salary cap and the CCSS remained unable to expand services more quickly because the state failed to meet legal requirements regarding its contributions to the institution's budget.

Finally, motivated by the severity of the CCSS' budgetary problems and both major parties' desire to sponsor social legislation, the salary cap was removed in 1971, a law centralizing public hospitals under CCSS authority passed in 1973, and most of the state's portion of social security quotas shifted to employers in 1974.¹⁰ The 1970s were a period of expansionary state policies in Costa Rica and two successive PLN (Partido Liberación Nacional or National Liberation Party) administrations (1970-74, 1974-78) made public cause of their commitment to universalizing social security. These governments made further good on their commitment to universalizing health services by increasing Ministry of Health budgets for preventative care and nutritional assistance to marginal rural and urban populations.¹¹

The CCSS is one of Costa Rica's many "semi-autonomous" institutions, meaning that its budget is separate from that of the central government and its policies determined by a tripartite board.¹² The CCSS employs over 31,000 people¹³ and manages a budget equivalent to nearly one-quarter of that of the central government.¹⁴ It is a highly centralized institution with all finance, management, and personnel resources and decisions emanating from the San José headquarters. Although the president, division managers, and regional directors are political appointees and change with each incoming government, other CCSS positions are not subject to political patronage and the institution is regarded as highly professional. The CCSS is also Costa Rica's most independent government institution. Constitutionally, its board of directors has complete autonomy from government interference in selecting institutional policies. Legal reforms passed in 2000 gave employer and worker organizations the power to choose their own representatives to the board, although the president's cabinet still chooses the government representatives. Finally, a law passed in November 2001 makes the CCSS the only government

institution to be entirely freed from the finance ministry's budget authority powers, including caps on hiring and salaries.

The Ministry of Health shares responsibility for public health with the CCSS. The ministry formulates policy for the sector, regulates medical markets, coordinates disease eradication efforts, monitors food and water quality, and conducts public health campaigns. In spite of the ministry's formal policy role, however, it has no real power over the CCSS. Until 1973, the Ministry of Health was more powerful in the realm of health policy than the CCSS, as it indirectly controlled almost all of the public hospitals. With the exception of the CCSS' own four hospitals, all public hospitals were administered by individual *juntas de protección social*, quasi-public bodies overseen by the Ministry of Health and funded by proceeds from the national lottery and various taxes and transfers from the central government. But legislation passed in 1973 transferred all public hospitals to the CCSS and the ministry was left without any control over their funding or administration. The Ministry of Health did maintain a position in the direct delivery of health services with the expansion of its health posts and mobile teams that was part of the drive toward universalization in the 1970s. But over time, CCSS clinics came to operate in many of the same areas as the ministry health posts and one of the objects of reform, discussed below, has been to eliminate overlapping services. Tables 1 and 2 illustrate the long-term decline in the Ministry of Health's resources and direct involvement in health services.

Table 1 about here

Table 2 about here

Antecedents to the Current Reforms

In the decades after its inception, the public health system all but wiped out the infectious diseases and infant diarrhea once responsible for high mortality rates in a young population. As Figure 1 shows, during the second half of the twentieth century, life expectancy lengthened while infant mortality rates dropped precipitously. The Costa Rican health system is also notable for its success in shrinking the gap between the quality of care afforded to urban and rural dwellers. And these achievements have been gained in a relatively cost-effective manner; currently, health expenditures per capita total U.S. \$285.¹⁵

Figure 1 about here

Problems in the Unified Public Health Sector

Despite these achievements, by the 1980s, the Costa Rican system showed the signs of trouble common to mature nation health plans: long waiting lists for diagnostic tests, surgery and specialist care, deteriorated hospitals and medical equipment, and a demoralized physician corps. The CCSS' own evaluation admits that: "There seems to be a general feeling of dissatisfaction regarding the functioning of the Health System, relating as much to its structure, financing, organization and management, as to its results."¹⁶ From the users' point of view, there is a problem of effective coverage as long waiting lists mean that many do not receive timely care for acute and potentially fatal conditions nor reasonable attention for smaller maladies. This situation has given rise to growing inequities in access to medical care as wealthier citizens often bypass the queues by purchasing private services and some people use personal connections to

arrange for “biombos” or illegal deals to secure preferential treatment. There are several reasons for these problems.

One is that the cost of Costa Rican health care has risen dramatically.¹⁷ Health care costs are being driven up, as in the rest of the world, by the increased use of sophisticated medical technologies and an aging population. Thanks to the success of the health system in treating and eliminating once-common infant diarrhea and infectious diseases and to declining birth rates, Costa Rica’s population is now older, healthier and living longer. But this older population presents a greater proportion of expensive, chronic, and degenerative diseases. The treatments for these maladies increase the cost of hospital stays, out-patient drug regimens, and physical therapies.

The second problem is that funding did not keep pace with rising costs, especially in the 1980s. As Table 3 shows, the foreign debt crisis and its aftermath resulted in decreased real public spending on health care as a proportion of GDP and in per capita terms for most of the decade. In addition, the CCSS suffered from tax evasion by private employers, large arrears from unpaid state contributions (on behalf of its own employees), and over-investment in low-yield government bonds throughout the same period.¹⁸ Insufficient funding contributed to deteriorating service in the regional hospitals, unmet demand in the national hospitals, delays in the acquisition of new technologies, and postponement of repair and replacement of the physical infrastructure. Over the last 20 years, CCSS facilities have also felt the strain of serving undocumented Central American immigrants, mostly Nicaraguans.¹⁹ The CCSS estimates that the difference between what the immigrants contribute to the system via payroll taxes and the services they receive equals 3.5 percent of the health system’s budget.²⁰

Table 3 about here

Finally, this imbalance between costs and resources has been aggravated by internal inefficiencies and inequities. One sort of inefficiency has been the declining productivity of the health system’s main human resource: doctors. Quantitatively, it is known that the number of consultations per doctor dropped between 1983-1995.²¹ Qualitatively, doctors attest to feelings of demoralization and apathy as they face the lack of incentives for professional achievement within the CCSS. In the clinics and hospitals, doctors work on a rough quota system with randomly-assigned patients. They are required to complete certain numbers of consultations and procedures but are not tracked according to the results of their care. Consequently, there are no rewards for doing a superior job or updating skills as new techniques become available. In addition, referrals are not tracked and hospitals do not bill clinics for them. This situation has created a perverse set of incentives for salaried doctors. Many fail to keep up in their fields. Others take shortcuts on CCSS consultations (by overusing referrals, for example) in order to leave more time for lucrative private practices.²²

Other aspects of inefficiency were rooted in the outdated accounting and management systems of the CCSS bureaucracy. The CCSS report describes its own managerial culture as a hierarchical and centralized one in which individual worker’s authority is very limited and merit-based performance incentives are inexistent.²³ For example, hospital budgets have traditionally been determined at CCSS headquarters based on the previous year’s spending. Hospital directors were, until recently, not accustomed to having the freedom or responsibility to determine how to allocate their resources to best serve their clientele and had little incentive to economize. In any case, that would have been difficult to do, as the CCSS did not know how

much hospital services cost in per-unit terms or the size and demographic characteristics of the population attended by each clinic.

The fact that budgets have been based on previous years' levels has also allowed inequities to crystallize within the system. Although the problem is not as bad in Costa Rica as in most other Latin American countries, health resources still tend to be concentrated in the capital and its environs, particularly because all of the national-level hospitals are located in San José.²⁴ In addition to this imbalance between the capital and outlying areas, there are budgetary imbalances between regions resulting from past decisions. There have been cases where local demands for more spending were granted, leaving certain clinics better endowed than other, similarly situated, units. Inequities have also arisen because areas which were once fast-growing received budget increases that were not reduced when they lost population while others did not gain the extra budgets they should have when populations expanded.²⁵

Early Experiments

In the early 1980s, Costa Rican officials could not have analyzed or foreseen all of the problems listed above. But they were aware of overcrowding in the clinics. Hence all of the institutional innovation between the consolidation of the system in the 1970s and the current reforms took the form of experiments with alternative forms of primary care delivery. As we will see below, this concern with primary care continued to dominate the Costa Rican health agenda into the 1990s.

During the 1980s, CCSS officials tried out three alternatives that might be called mixed medicine models, but none became the basis for the overhaul of the health system.²⁶ Under one plan, introduced in 1982, individuals could obtain appointments more easily by choosing a personal physician from a CCSS list and paying out-of-pocket for the office visit. The state continued to provide drugs and laboratory tests. The popularity of this program was limited by people's ability to pay, the slowness of CCSS laboratory services, and the amount of paperwork necessary to keep track of the doctors involved. Under another program introduced at about the same time, private firms paid the salary of a CCSS doctor to act as the primary physician of the company's employees and their dependents, while the CCSS continues to cover laboratory and pharmacy costs. This program was very popular among employers but the company doctors could not reduce waiting times for procedures in the hospitals or for test results.

Lastly, in 1988, the CCSS signed a contract with a private doctors' cooperative to run and maintain a fully-equipped clinic in a densely populated capital city suburb. Users were very satisfied with the clinic's services and four other such cooperatives received contracts to operate in San José. But the CCSS board of directors did not allow the model to expand further. Reportedly, the cooperative model drew heated opposition from technocrats within CCSS headquarters. They argued that the cooperatives' per patient costs were much higher than those of the traditional clinics,²⁷ accused the private medical groups of circumventing normal chains of command, and feared the institution would lose control over the medical delivery system.²⁸

The Current Reforms

Initial Design

From the point of view of the Costa Ricans involved in the process, the reforms designed in the early 1990s were motivated by the need for sectoral improvement, specifically in the area of primary care. It was the shortcomings of primary health care toward which attention had been most focused in Costa Rica. Throughout the 1980s, there were media reports about issues such as the long waits for appointments and shortages of medicines in the clinics' pharmacies. The public health system's negative image hit a low point in the first half of Rafael Angel Calderón Fournier's administration (1990-94) with an outbreak of measles and employers threatening to withhold insurance quotas because they were having to pay for private doctor office visits on behalf of employees.²⁹ In this context, Ministry of Health and CCSS officials invited World Bank representatives to Costa Rica to begin discussions about health sector reform. While the Costa Ricans remained focused on reworking the model of primary care, World Bank officials emphasized economic efficiency, the separation of purchaser and provider functions, and modernizing payment mechanisms.

In 1993, after 2 years of negotiations, the government signed a \$22 million health sector loan package with the World Bank.³⁰ The package contained three major components: 1) reorganization of the primary care model, 2) separation of the purchaser and provider roles, and 3) modernization of payment mechanisms. This package effectively represented a compromise between Costa Rican officials and World Bank negotiators.³¹ The Costa Ricans 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 and because the final agreement represented a giant retreat from the World Bank's initial proposal of privatization. During the negotiations, the World Bank had paid for Chilean consultants to offer recommendations about how to make the CCSS more efficient. Their proposals included creation of private health insurers, similar to the Chilean ISAPRES, and splitting the CCSS up into separate institutions for health financing, purchasing, and pensions. The Costa Ricans flatly rejected these proposals but did settle for the less radical idea of separating functions within the CCSS. Under this model, the central CCSS would purchase health services from its operational units. Competition among hospitals and clinics for provider contracts would breed efficiency within the system.

For its part, the World Bank finally agreed to accept the Costa Rican plan to overhaul the primary care system, a plan it rejected in initial discussions as too expensive. This plan was largely the brainchild of Dr. Fernando Marín, the director of the first private cooperative clinic contracted by the CCSS. The problem was that the CCSS' primary care services were purely curative and scattered around the country in a manner not necessarily corresponding to the distribution of the population. They were complemented in overlapping fashion by the Ministry of Health's preventative care and maternal-infant nutritional programs. Marín's idea was to replace this model with health care teams (EBAIS or Equipos Básicos de Atención Integral de Salud) which would provide integral care, that is, services attending to communities' physical, social, and psychological health needs. These teams would be distributed on a capitation basis, and would streamline public health services by taking over all direct medical functions provided by the Ministry of Health. The World Bank initially argued that the program would become unsustainably expensive if, as planned, each EBAIS were headed by a physician. But the Costa

Rican negotiators eventually won the point by arguing that much of the cost would be recouped by absorbing the resources of the Ministry of Health and that Costa Ricans would only accept health care provided by medical doctors.

The reform program was agreed with the World Bank in 1993; only then did Costa Rican officials begin consultations with stakeholders and the broader medical community. The CCSS team was focused on the EBAIS concept and very concerned about the opposition that might meet the plan of transferring all medical personnel from the Ministry of Health to the CCSS. The transfer was critical for supplying sufficient resources for the EBAIS to work, and, since the EBAIS were to be implanted on a national basis, had to be conducted fairly quickly. The Costa Rican team was led by Alvaro Salas, Director of Technical Services of the CCSS, and he took the proposal to the Schools of Medicine and Public Health at the University of Costa Rica, to the Colleges of Physicians and Nurses, and to largest of the many labor unions representing workers in the CCSS and Ministry of health. Most of the discussion concerned the EBAIS rather than other institutional reforms because the latter were much less detailed at that point. Regarding the separation of functions, the unions principally sought and received assurance that the CCSS would not be split up or privatized. Concerning primary care, one union in particular, ANEP (Asociación Nacional de Empleados Públicos), initially opposed the transfers because it would lose members as medical personnel migrated to the CCSS where they would be represented by other unions. The Colegio de Médicos had reservations about the EBAIS because they saw the health teams as practicing public health, not medicine. And even the Pan-American Health Organization became concerned that the changes in primary care might jeopardize Costa Rica's excellent track record in public health. PAHO sent representatives to San José to seek assurances from Costa Rican health officials.

In Costa Rica, all foreign loans contracted by government entities must be approved by congress, and so, at the outset, there existed the possibility that some of these objections might hold up approval, particularly because the legislative assembly would vote on the loan shortly before the 1994 elections. The loan had the approval of the President Calderón and his ministers but would the opposition PLN support it? In the end, the World Bank health sector loan received a unanimous vote of approval from the legislature. This outcome was facilitated in great part by the relationship between Alvaro Salas and PLN presidential candidate José Figueres. Costa Rica forbids the reelection of presidents or consecutive terms for legislators. Thus, as the PLN's presidential candidate, Figueres was the effective leader of the opposition in congress and his support was crucial in convincing the party to vote for health reform. Salas and his technical team had been working with Figueres to design his platform on health and convinced the candidate that he should support the loan package even though it had been developed under a different administration.

Implementation, Stage I: 1994-1998

After he won the presidential elections in February 1994, José Figueres appointed key members of the team which had negotiated the health sector loan with the World Bank to important positions. Alvaro Salas became the executive president of the CCSS. Hérmán Weinstock became Minister of Health and Fernando Marín Vice-Minister. Luis B. Saénz was appointed as Director of the CCSS-World Bank reform implementation unit and Norma Ayala was made coordinator of the EBAIS program. Together this core group constituted a change team committed to implementing the proposals they had developed. Not surprisingly, they

focused on that part of the program, the primary care model, which most powerfully motivated them. Plans for deconcentration developed much more slowly and would only gain center stage under the following administration.

Actual disbursement of the World Bank loan got off to a slow start, but the implementation team began restructuring primary care even before the external funding came in.³² Before establishing the first EBAIS in February 1995, the minister and vice-minister of health spent about six months negotiating terms with unions representing medical personnel to be transferred to the CCSS. As a result of these negotiations, transferred workers retained their seniority and the right to remain within the geographical area where they had always worked. Some felt the clash of organizational cultures as the public health-oriented Ministry of Health professionals joined the curative medical model of the CCSS, but the fact that CCSS pay scales were higher than those of the ministry must have helped ease the transition. And some of those eligible for pensions retired. In addition, reform team members traveled around the country educating ministry employees about working in the CCSS and talking to existing personnel about why and how primary care was changing. They also hired consultants to run workshops about the emotional aspects of change in the workplace. Approximately 1600 health ministry workers were transferred to the CCSS between 1995-1998.

Each EBAIS consists, minimally, of a medical doctor, nurse, and a technician and is responsible for a geographical area consisting of about 4000 people. Where necessary in rural areas, the EBAIS are mobile and travel around their territory. EBAIS are supported by personnel from the health area (*área de salud*, see below) to which they belong. The support personnel located in each health area include a family practitioner, nurse, laboratory technician, social worker, dentist, nutritionist, pharmacist, and medical records specialist. The last two positions were added after the EBAIS program had already begun. The College of Pharmacists insisted on inclusion of their professionals as there is a law which essentially mandates that only pharmacists can dispense medicines and the clerical position had to be added as record keeping turned out to be more challenging than originally imagined. Were it affordable, the CCSS would have liked to have included a psychologist in each group. In reality, not all health areas have a family practitioner and nutritionist yet, but no EBAIS can be formed without a medical doctor.

The administration of the CCSS decided that it would reflect most positively on the government if they constructed the new primary care facilities in the poorest areas of the country first. This meant beginning in the rural areas, and the first EBAIS was established in one of the poorest areas of the province of Puntarenas. Indeed, rural areas were served first, and, at this writing, EBAIS exist in all counties of the country save some portions of the Central Valley where the capital is located. As mentioned, there was some resistance to the EBAIS concept from physicians because of the feeling that their orientation was toward too much public health and that the doctors employed in them would not be able to use their technical training. Reportedly, surgeons at one hospital even accused the CCSS of dragging the medical profession back into the days of fighting parasitic diseases ("*parasitismo*"). But the reality is that Costa Rican doctors do not have many alternatives to working for the CCSS. In addition, because the CCSS had to hire many new doctors to staff the EBAIS, they are composed mainly of new medical school graduates, sparing the older physicians the need to change their attitudes.

During the administration of President Figueres, the EBAIS program expanded rapidly. By mid-1998, nearly 400 EBAIS, or about one-half the total originally planned, had been formed.³³ But the reform team progressed more slowly in the area of deconcentration. Because the original loan agreement offered few specifics in this regard, the reform team had to first

determine how it would work. They looked to foreign models for ideas, particularly Great Britain and Spain, and found the hospital contracting system of the autonomous region of Catalunya to be the most useful. Then they hired consultants from Spain and from Andersen Consulting to help design appropriate mechanisms for Costa Rica.

The central mechanism chosen was the *compromiso de gestión* or performance contract, an instrument that formalizes the relationship between central authorities and operating units. It guarantees a budget in return for the “production” of specified medical services and the achievement of quality standards. Performance contracts were first applied to the seven national hospitals in early 1997. In preparation, members of the CCSS reform team held countless meetings with hospitals in the last six months of 1996 explaining the new system and essentially negotiating what the division of responsibilities between the “purchaser” and “providers” would really look like. At first, the CCSS floated a more radical plan whereby hospitals would be quite autonomous, carry out their own personnel decisions, purchasing, and planning and bill the central authority *ex post facto* for services provided. But this version was roundly rejected by hospital authorities, unions, and CCSS management and quickly scrapped. Particularly important is that labor unions have from the beginning managed to defeat all proposals that hiring and firing be carried out by operating units. The idea that hospitals bill for services provided rather than receive all or most of their budgets at the beginning of the year also died in these exploratory discussions. In fact, many hospital administrators and employees voiced rejection of any sort of performance contract. They did not like the idea that the CCSS management planned to measure their efficiency and reward or penalize them accordingly.

Upon launching the performance contract system for the seven national hospitals in 1997, the reform team published *Hacia un nuevo sistema de asignación de recursos*, a document which explained the future system envisioned by planners. As a first step, hospitals would receive a budget from which 10% would be withheld for use as performance incentives. The value of all hospital procedures would then be calculated and expressed as hospital production units (UPHs or *unidades de producción hospitalaria*). In later phases, these calculations would be refined to incorporate two additional variables: average hospital stays and standard costs per case mix. The performance contract would stipulate the expected production of the hospital in terms of UPHs and other outcomes related to quality (e.g. length of waiting lists, numbers of inter-hospital infections). Hospitals whose performance fell short of the actual UPH’s promised would be deemed inefficient and intervened by the central administration. Those which met or exceeded the goals would be efficient and have access to the incentive funds at variable rates.

Health areas (*áreas de salud*), or the administrative units responsible for primary care, would also be put on performance contracts and experience a phased transition.³⁴ Ten percent of their budgets would also be withheld and then returned in full or in part depending on whether the actual production and quality of services met the stipulations of the performance contracts. Health areas’ budgets would gradually shift from being determined according to previous levels to being assigned on a capitation basis corrected for age, sex, and epidemiological factors. In addition, hospitals were to begin charging health areas for each patient referred to them, thereby providing an incentive to resolve cases on the primary level.

At the end of 1997, the CCSS evaluated the hospitals according to the criteria of the performance contracts and released full details to the media. The hospitals were angered by the release of so much information and the most vocal of the opponents to the new system, the director of the Calderón Guardia Hospital, called a special session of the CCSS board of directors to make his case against the reforms. At the end of a long and emotional meeting, it

became clear to the director that the board did not support him. His subsequent resignation seemed to break the resistance of the hospitals. Before President Figueres left office in May 1998, the CCSS signed performance contracts with the rest of the hospitals in the system and with the health areas. As the next section will explain, however, the budgeting system never evolved as envisioned in *Hacia un nuevo sistema de asignación de recursos*.

Implementation, Stage 2: 1998-2002

With the presidential elections of 1998, the government changed presidents and parties, and this brought significant modifications in the context and priorities of the health reform agenda. The impetus behind the formulation and initial implementation of the health reforms had been largely sectoral, as the changes were developed to address problems in public health administration and not explicitly linked to on-going structural adjustment measures. The incoming administration of Miguel Angel Rodríguez, however, saw the health reform package as one of several initiatives intended to improve the functioning of the social security system, which, in turn, was defined as a key aspect of state reform. The government's new change team directed both pension and health reform. In health, this group placed a much stronger emphasis on role division and other institutional changes than on the primary care system.

The hand-over of the health reform project between the Figueres and Rodríguez administrations was facilitated by meetings during which outgoing officials educated the newcomers in the details of the reforms. But key players left office or were sidelined by the new leadership. The president of the CCSS, director of the reform project, and managers of the EBAIS and budgeting (*asignación de recursos*) components left or were reassigned to other, unrelated positions within the institution. A new change team with different priorities took office. This team included the new executive president of the CCSS, his advisors, and the new chief of the modernization and development division. The modernization and development division was itself a new creation within the CCSS and its head became the director of the reform project.³⁵

The new team was more focused on administrative deconcentration and other institutional changes than on the primary care system.³⁶ But they could not discontinue the EBAIS concept, as the health teams had become popular and communities not yet covered were demanding theirs. So during 1998-2002, the reform project continued to transform the primary level of care by forming new EBAIS, but at a slower pace than previously. At year-end 2001, there were 736 EBAIS covering about 80% of the population.³⁷ And, as Table 4 shows, by the end of the decade, there was a clear shift of resources from hospital spending toward primary care. This shift has been facilitated by a budget that is expanding in per capita terms (see Table 5) meaning that relative increases can be made in primary care without taking resources away from higher level institutions.

Table 4 about here

Table 5 about there

CCSS officials also completed several institutional reform efforts. One was to create a formal evaluation system with which to measure the quality of CCSS medical services and user satisfaction. To this end, the CCSS established SUGESS (Superintendencia General de Servicios de Salud) in 1999. SUGESS monitors quality indicators such as waiting lists, performs surveys

of user satisfaction, collects complaints via 124 offices around the country, and disseminates information to clients about their rights and responsibilities. Although it is an internal unit, SUGESS maintains substantial autonomy from political appointees because the superintendent and regional directors have permanent, lifetime employment rights (*propiedad de plaza*) and cannot be removed from their jobs.³⁸

Another institutional reform brought to fruition during the Rodríguez administration was the installment of a new CCSS collection system, that is, the mechanism by which the institution collects monthly pension and health quotas from workers and employers. The commitment to modernize collections had, at the urging of the World Bank, been included in the original health sector loan agreement. But the new system, SICERE (Sistema Centralizado de Recaudación) was only implemented in 2001. SICERE is intended to make payment of social security taxes easier, faster, and more traceable, thereby reducing evasion. Before the new system, employers had to send someone to a CCSS office every month to pay the taxes and the transaction was handled entirely by hand. SICERE makes this unnecessary because it can automatically deduct payments from employers' bank accounts or accept payments at bank locations. SICERE has greatly sped up the process of updating company payments records and now provides data about taxes paid for individual employees.³⁹

Of course, SICERE improves the collection of social security taxes destined to the CCSS pension system as well as to health accounts, and because of this, the Rodríguez administration prioritized its completion. The connection is that the collection system needed to be automated so that the new complementary pension system, also put into place in 2001, could work. Thus the president of the CCSS was very involved in drafting and lobbying for the *ley de protección al trabajador*, a law passed in early 2000 which mandated the creation of an obligatory, private pension scheme to complement the state system. The new law further aims to enhance the financial situation of the CCSS by mandating the absolute universalization of health and pension systems, ordering the CCSS to begin collecting quotas for these programs from the entire economically active population, including informal sector workers, by 2005.

The bulk of the second health reform team's energy, however, has gone to furthering and formalizing the deconcentration process. Nevertheless, only a small portion of the blueprint laid out in *Hacia un nuevo sistema de asignación de recursos* has been implemented.⁴⁰ Hospital production is measured in UPH's but the calculations are used more than anything to justify spending, as the basis for budgeting remains historical. What is more, CCSS statisticians know that the cost of UPH's varies among hospitals, but so far health authorities have not employed case mix methodology to counter this. The movement toward capitation-based budgeting for health areas is also incomplete. Here reformers have used historical budgets as a base, but because the budget for primary care is growing more rapidly than that of hospitals, they are addressing inequalities by awarding extra amounts to underfunded areas. All area budgets are growing at least as fast as inflation, but some are increasing more rapidly than that. In addition, health units do receive a financial incentive for efficient production (i.e. scoring above 85 out of 100 on their annual review) but this has been reduced to an amount equaling two percent of the unit's budget. There are no penalties for inefficiency or scoring lower than 85 on the annual evaluation and, so far, no hospital or health area has lost any portion of its budget. Finally, virtually no progress has been made in advancing a direct billing system between hospitals and clinics for referrals.

The limitations in relating budgets to performance and the disuse of penalties reflects the resistance of health units to these measures and the conscious restraint of CCSS officials. The

reformers have tacitly agreed to accept a very slow pace of deconcentration at least in part because they fear a backlash from administrators and labor unions if pushed harder. CCSS managers admit that it will take at least five more years to really make budgeting dependent on performance contracts.⁴¹

The current change team has met with much more success in translating deconcentration into national law. The president of the CCSS and his main advisor, both lawyers, drafted the *ley de desconcentración de los hospitales y clínicas de la Caja Costarricense de Seguro Social*, which was passed by the legislative assembly in late 1998. The law passed through congress easily, to the extent that even its authors were surprised. There was virtually no opposition from labor unions or the PLN, probably because the law did not propose any type of privatization nor mention the words “competition,” or “market” in any form. The CCSS administration presented the draft law to health sector labor organizations before taking it to congress, and obtained a letter of support signed by union leaders. In addition, the law is short and vague, as the detail would only be added later in the *reglamento* published by the CCSS. And the largest portion of the law discusses the creation of the *juntas de salud*, or the locally elected health committees, giving the legislation the appearance of promoting community participation more than anything else. Finally, the Social Issues Commission, the congressional committee which examined the law before recommending it to the plenary, held a public hearing at which several well-known doctors endorsed the idea.

Although the authors of the legislation were inspired by regional trends toward political decentralization, they settled for the limited concept of deconcentration as more appropriate for Costa Rica’s still highly centralized state. Here deconcentration means only the redistribution of management power and responsibilities from the central administration toward the units directly providing medical services within the same national institution. The 1998 *ley de desconcentración* offers hospital and clinic directors independent legal status (*personalidad jurídica instrumental*) such that they can execute contracts with third parties and manage their own budgets and human resources so long as they abide by the terms of performance contracts, CCSS regulations, and national law. The new law also changes the conditions of employment for directors from lifetime appointments to five-year contracts.

The other important change brought about by the *ley de desconcentración* is the creation of the *juntas de salud*, seven-member bodies composed of three representatives elected by citizens directly insured by the CCSS, two chosen from employers organizations, and two from community organizations (these cannot be labor unions). The CCSS officials who drafted the 1998 law saw community involvement as an essential balance to the power of the central health administration. There are 124 *juntas de salud*, one for each of the hospitals and larger clinics in the country. *Juntas de salud* are elected every two years in November; the timetable for these elections was designed specifically not to coincide with political elections so as to avoid linkages to partisan competition.⁴² Their purpose is to oversee and supply input into a diverse array of functions carried out by the hospitals and clinics including: execution of the budget and other managerial matters, contents of the performance contracts, and the selection of directors, as well as promoting health projects within the community. Thus far, there have been two elections for the *juntas de salud*, and for each only about 14,000 of one million eligible voters cast ballots.⁴³ A survey of the first *juntas* conducted by SUGESS found that three-quarters of them had not participated in the administration of their corresponding health unit and that the biggest obstacle they confronted was the local CCSS authorities’ refusal to cooperate.⁴⁴ CCSS officials admit

that there is a great deal of variation in the actual participation rates of individual *juntas* and that it will be years before they reach their potential.⁴⁵

Hospitals and clinics were not automatically deconcentrated as a result of the 1998 law and subsequent *reglamento*. Rather, the CCSS board of directors retained the authority to set up a process of transition for the health units, as well as the right to withdraw deconcentrated status from any hospital or clinic that mismanaged its responsibilities. Hospitals and clinics are eligible to apply for deconcentrated status when they have a signed performance contract and composed a functioning *junta de salud*. The board of directors approved the first group of 14 hospitals for deconcentrated status in 1999. Since then, 20 more hospitals and clinics have received deconcentrated status. These 34 units include all of the national hospitals and represent over 70 percent of CCSS health spending and services.⁴⁶ Health officials say that they are happy with the gradual, phased pace of deconcentration because it allows both the operating units and the central administration time to make what are often cultural changes in the organization of their work. These authorities report that it took some prodding to motivate the first group to ask for deconcentrated status, but that the pace of applications has since sped up. Officially, deconcentration is strictly voluntary. In reality, central health authorities have constructed a set of sticks and carrots that push health units toward independence. The carrot is the independence gained by hospital and clinic directors to govern their own institutions. The stick is the knowledge that until the institution gains deconcentrated status, it will continue to receive instructions from the central or regional administration and sacrifice control over purchasing and other managerial matters.

Deconcentration in Practice

Deconcentration has had a variable impact on intrabureaucratic relationships. On the one hand, hospital and clinic directors in place before the 1998 law were allowed to keep their permanent appointments. This has allowed pre-established patterns to continue in some areas. On the other hand, deconcentration is forcing rapid improvements in the notoriously difficult relationships between hospital directors and administrators. Hospital directors have always been doctors promoted from within their institution to a position of medical leadership. The actual management of the hospital's budget was usually left to its administrator, traditionally appointed by CCSS central authorities. Rifts often developed between the director seeking to protect his or her own institution and the administrator, often viewed as a spy from headquarters. Now the directors of deconcentrated hospitals can choose their own administrator and the two are forced to work together to meet performance contract goals. Finally, the deconcentration process has largely undercut the power of the regional directors. The directors of the seven national hospitals always negotiated directly with the CCSS central administration, but smaller hospitals and all clinics reported to one of eight regional directors who passed on annual budget allotments to each unit and had substantial control over purchasing and human resource matters within their areas. With deconcentrated status comes independence from regional directors, something most hospitals and clinics are happy to have, although they often turn to their former superiors when problems arise.⁴⁷

While the directors may have resisted performance contracts and deconcentration at first, they now jealously guard their new independence. Hospitals and clinics appreciate the transparency of the central administration's budgetary obligation toward them as spelled out in the performance contracts, whereas in the past the CCSS sometimes withheld promised funds

because of financial problems. The new right clearly cherished the most by hospital directors is that of independent purchasing. By doing their own purchasing, hospitals have more control over what they are buying and can execute the process more rapidly.⁴⁸

But there are numerous restrictions on the actual freedom exercised by deconcentrated units. For example, a number of factors constrain hospital directors' discretion over budgets. Payrolls typically account for over 60 percent of hospital budgets and without the power to reduce the number of employees or tamper with their wages, this puts a large portion of total expenditure outside of the directors' control. In addition, directors must obtain permission from central authorities to transfer any significant amount of money (over five percent of total budget) from one purpose or department to another. Without user fees, hospitals have few opportunities to raise funds independently. The one clear exception is that they may accept donations from community fundraising activities. Only the children's hospital seems to benefit much from this as it receives money from an annual telethon. Although hospitals may generate profits by selling non-medical services (e.g. parking lot fees), they are not allowed to keep them. CCSS central authorities have also decided to retain control over some purchases, because, they argue, to allow decentralized decisionmaking would waste resources. Thus all medicines are purchased by the central administration. And the CCSS recently ordered hospitals to suspend plans for independent acquisition of computerized information systems arguing that it intends to purchase a system-wide package.

Negotiations between central CCSS authorities and labor unions representing employees in the health sector also overshadow the possibilities for independent decisionmaking by hospital and clinic directors in two key areas: human resources and private contracting. Deconcentrated units were to receive substantial autonomy in human resource decisions but this area continues to be governed by negotiations between central CCSS authorities and labor organizations. The central administration retains control over the creation of new positions and directors must respect salary scales previously negotiated. The unions have steadfastly resisted any attempt to tie the salaries of medical personnel to performance indicators. They have agreed to allow deconcentrated units to transfer employees, but only within an eight kilometer radius. In these cases, the employee's salary follows him or her to the new post, leaving directors little incentive to make transfers. Hospital and clinic directors are also not able to force changes in working conditions previously negotiated (i.e. schedules) and so rely on new hires to work unpopular shifts. Firing employees can only be done according to civil service regulations. There has been no move by any unit or by central level managers to make labor shedding part of the reforms.

Other than protecting their salaries and working conditions, the main concern of the health sector unions is to limit or eliminate the contracting of private medical services by clinics and especially hospitals. Payments for private services account for only two percent of the CCSS budget.⁴⁹ They are concentrated in a few areas such as radiation therapy, where technology lags are most acute and the need to reduce waiting lists is most pressing. A private clinic also recently won a bid to administer several EBAS in the San José metropolitan area. The World Bank sponsored reforms did not explicitly promote the contracting of private services and health officials did not foresee that labor union opposition to this practice would become a focus of dispute between the two sides. But third-party contracting has grown in the last decade, been widely publicized by the media, and attacked by labor unions as a plot by reformers to privatize the CCSS.

In addition, the question of third party contracting by hospitals has been plagued by conflicts of interest wherein CCSS specialists have referred patients to their own private

practices for treatment. Not only labor unions but many of the individual doctors I interviewed are concerned that the deconcentration of purchasing will only lead to more such corrupt practices. The position of the labor and professional organizations representing health workers is that using small quantities of CCSS funds to purchase private diagnostic tests and treatments rather than better equipment for the public sector will result in the latter falling farther and farther behind as potential investment is effectively siphoned off to private clinics.⁵⁰ In an October 2001 agreement between the unions and the CCSS, the CCSS agreed to curb the growth of third-party contracting by increasing investment in the entire public health sector toward a goal of 10 percent of GDP, place stricter limits on private contracting by deconcentrated units, and study the possibility of requiring newly hired health professionals to forgo private practice.⁵¹

Conclusion: A Mix of Rapid and Gradual Reform

The one clear success of the Costa Rican health reforms is the reorganization of primary care through the EBAIS. Interestingly, this is the only portion of the health reforms whose pace and scope could be called rapid, at least during the first phase of implementation. Before implementing the EBAIS, officials took care to negotiate the terms of employee transfer from the Ministry of Health to the CCSS. This concerted effort to diffuse potential opposition to the plan meant that the government reaped almost nothing but advantage from the new EBAIS. Rapid implementation on a national scale, beginning in the humblest *cantones* and moving in toward the capital gave the impression that the government was moving quickly to help the poor and to modernize the health system. The CCSS counted the EBAIS and took photographs of their newly painted buildings as evidence of recent achievements in health reform. Communities that had gotten their own EBAIS arose quickly as new stakeholders, and this created demands from other communities for the same benefit.

Deconcentration has progressed much more slowly. The pace of change from a system of historical budgeting and centralized decisionmaking toward independent management and financial accountability has been incremental. In addition, the scope of deconcentration, both in terms of the proportion of health units involved and the range of rights and responsibilities transferred, has been only gradually expanded. This gradualism is part strategy, part compromise. We can identify proactive decisions taken by the reform teams (e.g. the decisions to begin performance contracts with a pilot project in the seven national hospitals, make health units apply for deconcentrated status, grandfather hospital directors with permanent appointments) which were clearly meant to promote gradual change from the old model to the new one. But, to be sure, health reformers have had to make many compromises on their original plans in the face of opposition from various sectors of the CCSS. For example, hospitals have successfully rejected original designs to penalize them for inefficiency and labor unions have blocked efforts to deconcentrate human resource policy and curbed hospital director's independence in purchasing decisions.

There are a number of advantages and disadvantages to this incremental approach to health reform as a political process, regardless of what one may think of its goals. On the positive side, given that the reforms require changes within the most complex units of the CCSS (hospitals and central administration), it seems justified to allow time for the corresponding shifts in organizational culture to develop. And, in the meantime, the process of deconcentration is creating new stakeholders (hospital and clinic directors) who are pushing for more independent decisionmaking power. On the other hand, there may well be significant opportunity costs, in

the form of forgone efficiency gains, for not holding hospitals accountable for their budgets sooner. The gradual nature of reform has also allowed labor unions the time to organize to limit the process. Finally, it is possible that the result of negotiating each step of the process means that the endpoint originally envisioned, the separation of purchasing and providing functions in some sort of quasi-market, will never be reached.

¹ John Ickis, Carlos Sevilla, and Miguel Iñiguez, “Estudio del sector salud de Costa Rica,” Alajuela, Costa Rica, Instituto Centroamericano de Administración de Negocios, June 1997, 83; and CCSS, *Plan de atención a la salud de las personas: 2001-2006* (San José, 2001): 56.

² Rodolfo E. Piza Rocafort, *Seguridad Social: Nova el vetera* (San José: Editorial Nacional de Salud y Seguridad Social, 2001): 83.

³ James Cercone, Fabio Durán, and Rodrigo Briceño, “El desempeño del sector social en Costa Rica durante la década de los noventa,” San José: Instituto Latinoamericano de Políticas Públicas and SANIGEST, November 2001, 47. Hospitals are supposed to charge uninsured people for services but this is not always done, especially when the patient is a foreigner. In addition, uninsured people will sometimes begin to pay social security contributions the month before being admitted for hospital procedures in order to be fully covered, and then discontinue payments immediately afterwards.

⁴ Juan Diego Trejos, Leonardo Garnier, Guillermo Monge, and Roberto Hidalgo, “Enhancing Social Services in Costa Rica,” in Cristián Aedo and Osvaldo Larrañgo, eds., *Social Service Delivery Systems: An Agenda for Reform* (Washington D.C.: Inter-American Development Bank, 1994): 56; Ickis et. al., “Estudio del sector salud,” 108; and Interview with Eduardo Flores, President, Colegio de Médicos y Cirujanos de Costa Rica, San José, December 8, 2001.

⁵ Cercone et.al, “El desempeño del sector social,” 37.

⁶ Ibid., 37, based on author’s calculations of data in Table 5.5.

⁷ Ibid., 65.

⁸ Mark Rosenberg, *Las luchas por el seguro social en Costa Rica* (San José: Editorial Costa Rica, 1983): 45-130 passim.

⁹ Guido Miranda Gutiérrez, *La seguridad social y el desarrollo en Costa Rica* (San José, Editorial Nacional de Salud y Seguridad Social, 1994): 123-24.

¹⁰ Rosenberg, “*Las luchas*,” 171-179.

¹¹ Juan Jaramillo Antillón, *Salud y seguridad social* (San José: Editorial de la Universidad de Costa Rica, 1993):73-77.

¹² The CCSS board of directors has 9 members: 3 government officials, 3 from the business chambers, and 3 representing workers (1 from the labor unions, 1 from the *solidarista* employees’ groups, and 1 from the cooperative sector). The executive president of the CCSS is a member and chair of the board.

¹³ CCSS, *Plan Anual Operativo Institucional: Año 2002* (San José, 2001): 68.

¹⁴ Based on author’s calculations of data from: Contraloría General de la República, *Memoria Anual 2000* (San José, 2001). Data refer to year 2000 budget.

¹⁵ Pan-American Health Organization, on-line data generator.

<www.paho.org/English/SHA/CoreData/Tabulator/>

¹⁶ CCSS, Proyecto Modernización, *Hacia un nuevo sistema de asignación de recursos* (San José, 1997): 9.

¹⁷ Ibid., 20.

¹⁸ Inter-American Development Bank, “Costa Rica: Health Services Improvement Program,” Washington D.C., November 1992, 31.

¹⁹ In 1999, conservative estimates put the number of Nicaraguans living in Costa Rica at 340,000-360,000, or 10 percent of Costa Rica’s population. Giannina Segnini, “Nicaraguenses no superan los 400 mil,” *La Nación*, 5 December 1999.

<www.nacion.co.cr/ln_ee/1999/diciembre/05/>

²⁰ Giannina Segnini, “Nicaraguenses impactan salud,” *La Nación* 7 December 1999.

<www.nacion.co.cr/ln_ee/1999/diciembre/07/>

²¹ Ickis et.al., “Estudio del sector salud,” 93.

²² Interview with Manuel Piza, Director of Medical Administration, Colegio de Médicos y Cirujanos de Costa Rica, San José, July 31, 1997.

²³ CCSS, *Hacia un nuevo sistema*, 22-23.

²⁴ *Ibid.*, 36.

²⁵ Interview with Rodolfo Piza, Executive President, CCSS, San José, December 4, 2001.

²⁶ Much of the information in this paragraph comes from Ickis et. al., “Estudio del sector salud,” 108-111, 130-131.

²⁷ Interview with Fabio Durán, former Director of the Actuarial Department, CCSS, San José, December 10, 2001.

²⁸ Interview with Roger Ballestero, Coordinator, CCSS-IDB health reform project, San José, July 22, 1997; and Juliana Martínez, “Poder y alternativas: la disponibilidad de agendas internacionales en las reformas de la salud en Costa Rica: 1988-1998.” unpublished manuscript, San José, July 1999.

²⁹ Interview with Alvaro Salas, former Executive President of the CCSS, San José, December 5, 2001.

³⁰ The government signed a \$42 million loan package with the IDB the same year. Most of this loan was earmarked for the construction of a replacement hospital in Alajuela, the negotiations for which had been taking place over a period of nearly 10 years. These negotiations were not related to health sector reform discussions with the World Bank, although before the agreement was signed, support for repair and construction of public health buildings and redefining the role of the Ministry of Health was added.

³¹ Information on the positions of the World Bank and Costa Rican negotiators comes from interviews with Alvaro Salas; James Cercone, former World Bank official and former member of the Proyecto de Modernización de la CCSS, San José, December 10, 2001; and Norma Ayala, former member of the Proyecto de Modernización de la CCSS, San José, December 12, 2001.

³² General information on implementation in 1994-98 is based on interviews with Alvaro Salas, Cercone, Ayala, Luis B. Saénz, former director of the Proyecto de Modernización de la CCSS, San José, December 11, 2001; and Rigoberto Salas, president of SIPROCIMECA (Sindicato de Profesionales en Ciencias Médicas de la CCSS e Instituciones Afines) and coordinator of FOSS (Frente de Organizaciones Sindicales del Sector Salud), San José, December 14, 2001.

The team only carried out the steps necessary to make the project “effective,” in World Bank terminology, in 1995. Then they discovered that the loan had not been included in the regular 1995 government budget and had to wait until the next special session to add it, meaning that loan disbursement did not start until early 1996.

³³ Mary A. Clark, *Gradual Economic Reform in Latin America: The Costa Rican Experience* (Albany: SUNY Press, 2001): 91.

³⁴ Although there are more clinics than health areas in Costa Rica, there is generally one large clinic (combining primary care with some specialist services such as obstetrics/gynecology, dermatology, pediatrics, psychiatry, etc...) per area. Thus performance contracts are normally signed by the director of the clinic as the officer responsible for the entire health area, including all EBAIS assigned to the location.

³⁵ Interview with Rigoberto Urbina, legal advisor to the CCSS president, San José, December 4, 2001.

³⁶ Interview with Rigoberto Urbina, San José, December 3, 2001; Interview with María Isabel Solís, Proyecto de Modernización de la CCSS, San José, December 6, 2001; Interview with Ayala.

³⁷ Interview with Solís.

³⁸ Interview with Roberto Galvas, superintendent of SUGESS, San José, December 4, 2001.

³⁹ Interview with Cercone.

⁴⁰ Information in this section is based on interviews with: Durán, Saénz, Solís, Flores, Rodolfo Piza, and Claudio Arce, Proyecto de Modernización de la CCSS, San José, December 10, 2001.

⁴¹ Interview with Rodolfo Piza and Juan Carlos Sánchez Arguedas, Manager, Modernization and Development Division, CCSS, San José, December 7, 2001.

⁴² Interview with Urbina, December 3, 2001.

⁴³ Ibid.

⁴⁴ SUGESS, “Informe sobre el funcionamiento de las juntas de salud,” San José, 2001.

Accessed through <www.nacion.com/ln_ee/ESPECIALES/informes/caja/juntas.html>

⁴⁵ Interview with Urbina, December 3, 2001.

⁴⁶ Interview with Rigoberto Urbina, San José, December 12, 2001.

⁴⁷ Interview with María Eugenia Villarta, Director of the Central South Region, CCSS, San José, December 11, 2001.

⁴⁸ One director said that purchases made through the central CCSS took 6-12 months but that made independently, they take 3 months. Interview with Rodolfo Hernández, Director, Hospital de Niños, San José, December 13, 2001.

⁴⁹ Interview with Rodolfo Piza.

⁵⁰ Interview with Rigoberto Salas.

⁵¹“Declaración Conjunta CCSS-Organizaciones Sindicales y Sociales: Relativa al Futuro de la Seguridad Social en las Áreas de Autonomía Institucional, Financiamiento y Reforma de Servicios de Salud y Pensiones,” San José, October 29, 2001. This agreement was concluded after nearly a year of negotiations mediated by the Catholic Church, but the largest and most radical labor union representing CCSS workers refused to endorse it.

Table 1: Total Inpatient Beds (Hospitals and Clinics)

Year	1970	1990	2000
Ministerio de Salud	5659	197	0
CCSS	1045	6536	5924
Private Sector	300	124	196
Total	7004	7173	6120

Sources: Data for 1970 and 1990 from Guido Miranda Gutiérrez, *La seguridad social y el desarrollo in Costa Rica* (San José, Editorial Nacional de Salud y Seguridad Social, 1994): 133. Data for 2000 from CCSS, *Plan de atención a la salud de las personas: 2001-2006* (San José: 2001): 56 and Interview with Eduardo Flores, President, Colegio de Médicos y Cirujanos de Costa Rica, San José, December 8, 2001.

Table 2: Distribution of Public Health Spending (% of total)

Year	1976	1980	1990	1999
Ministerio de Salud	33.7	32.2	11.4	7.4
CCSS	50.9	50.7	77.1	80.2

Note: Percentages do not add to 100 because spending by other agencies on sewerage and water and insurance are omitted.

Sources: Data for 1976, 1980, 1990 from: Guido Miranda Gutiérrez, *La seguridad social y el desarrollo in Costa Rica* (San José, Editorial Nacional de Salud y Seguridad Social, 1994):232. Data for 1999 from: James Cercone, Fabio Durán, and Rodrigo Briceño, “El desempeño del sector salud en Costa Rica durante la década de los noventa,” (San José: Instituto Latinoamericano de Políticas Públicas and SANIGEST, November 2001): 35.

Table 3: Spending on Public Health, 1978-1990

Year	public health spending as % of GDP ^a	public health spending/capita (in constant 1985 colones)
1980	8.0	5531
1981	6.9	4316
1982	5.7	4394
1983	6.2	4527
1984	6.3	4688
1985	6.6	4951
1986	7.0	5489
1987	6.8	5386
1988	7.0	5314
1989	7.6	5516
1990	7.7	5361

^aIncludes expenditures by the CCSS, Ministerio de Salud, Instituto Nacional de Seguros (accident rehabilitation and worker's compensation only), University of Costa Rica (training of health professionals), and Instituto Costarricense de Acueductos y Alcantarillados.

Sources: CCSS, "El Gasto Público en Salud: metodología y estimación 1980-1993," Departamento de Estadística, July 1994, 15-16; and Juan Jaramillo Antillón, *Salud y Seguridad Social* (San José: Editorial de la Universidad de Costa Rica, 1993): 177.

Table 4: CCSS Health Spending, by level

as a % of total	1997	1998	1999	2000
Primary care	19	19	20	26
Second & third level care (mostly hospital)	81	81	80	74
Total	100	100	100	100

Source: James Cercone, Fabio Durán, and Rodrigo Briceño, "El desempeño del sector social en Costa Rica durante la década de los noventa," San José: Instituto Latinoamericano de Políticas Públicas and SANIGEST, November 2001, 60.

Table 5: Spending on Public Health, 1990-1999

Year	public health spending as % of GDP ^a	public health spending/capita (in thousands of 1995 colones)
1990	5.9	29.7
1991	5.7	27.9
1992	5.4	27.7
1993	6.0	32.2
1994	5.8	32.8
1995	5.8	32.7
1996	6.0	33.3
1997	5.7	32.9
1998	5.5	33.8
1999	5.3	35.3

Note: Because of methodological differences, data in Table 5 are not comparable to data in Table 3.

^aIncludes expenditures by the CCSS, Ministerio de Salud, Instituto Nacional de Seguros (accident rehabilitation and worker's compensation only), University of Costa Rica (training of health professionals), and Instituto Costarricense de Acueductos y Alcantarillados.

Sources: James Cercone, Fabio Durán, and Rodrigo Briceño, "El desempeño del sector social en Costa Rica durante la década de los noventa," San José: Instituto Latinoamericano de Políticas Públicas and SANIGEST, November 2001, 36.