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**THE COSTA RICAN SOCIAL SECURITY FUND'S  
ALTERNATIVE MODELS:**

**A CASE STUDY OF THE COOPERATIVE-BASED,  
COOPESALUD PAVAS CLINIC**

*Summary Report, March 1992*

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***HEALTH CARE IN COSTA RICA***

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Costa Rica's epidemiological profile is that of a developed country. Its infant mortality rate is less than 15 per 1,000 live births. With relatively few exceptions, major immuno-preventible diseases have all but been eradicated. There exists a general national, as well as international, consensus that the Costa Rican health system -- and specifically its Social Security System (Caja Costarricense de Seguro Social, known as the Caja) -- has played a fundamental role in bringing about these conditions and in achieving the high health status of the people of Costa Rica.

Until the 1980s, the Caja functioned primarily as a passive service provider -- serving the curative needs of the population while the Ministry of Health (MOH) provided preventive care through ambulatory clinics. More recently, there have been efforts to integrate services provided by the Caja and the MOH in order to optimize the use of resources and avoid duplication of services. An important element in this integration was the establishment of equal remuneration of professional and technical personnel at both the Caja and the MOH. At the same time, there has been a move towards providing comprehensive health services to the entire population, including the very poor, at a cost consistent with the country's ability to pay. As part of this movement, the Caja has begun focusing its efforts on providing more preventive care.

The Government of Costa Rica's desire to

contain costs has also led to greater integration of private and public health care. In 1990, 84% of doctor visits were through the public sector, with 16% in the private sector. At present, Caja hospitals provide clinic space for private practitioners and 25% of physicians working for the Caja also maintain a private practice. In some instances, patients pay their private physicians but the Caja covers the cost of laboratory work and prescriptions.

Despite the Caja's success in providing coverage to 83.2% of the population (World Bank 1990), there has been a growing crescendo of complaints about various aspects of the Social Security System. Increasingly plagued by diseconomies of scale and the demands of 22 different unions, the hierarchical, bureaucratic Caja structure with its 25,599 employees has come to be an increasingly expensive, highly centralized, and depersonalized provider of services to the growing dissatisfaction of users and providers alike.

Motivated by macroeconomic and political considerations and desirous of improving efficiency and quality of care, the Caja has decided to develop alternative models of care, one of which is the Pavas Cooperative Clinic.

***PAVAS CLINIC -- ORIGINS AND FINANCING***

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There are presently two cooperatives to which the Caja, acting in the capacity of a

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third party payer, has rented equipped facilities and paid an annual stipend. Of the two cooperative clinics in Costa Rica, the Pavas Clinic (COOPESALUD) is the oldest. Constructed in 1987, the clinic is located on the periphery of the capital city of San Jose in an area made up of a marginal urban population of the lower middle and lower classes and two wealthy barrios. The population of the area numbers approximately 55,000 and is still growing due to the influx of migrants from smaller towns and rural areas of Costa Rica.

The original Caja agreement with COOPESALUD to run the Pavas Clinic set out a time-limited, two-year experiment. But while the term "project" and "model" continue to be used to describe the arrangement, the attitude within the Caja is that this operation is of a permanent nature.

### **Objectives**

In developing the cooperative model, the Caja hoped to achieve a number of objectives, including:

- To extend health coverage without excessive commitment of public funds.
- To reduce the size of the Central Government by transferring public responsibilities to the private sector.
- To increase patient satisfaction by providing some form of incentive to the service provider.
- To create a personalized physician-

patient relationship with an emphasis on family and community health.

To integrate preventive and curative services and to address the epidemiological profile of the population without requiring additional diagnostic resources or sophisticated treatment.

### **Organizational Structure**

Costa Rican law delineates detailed requirements for the structure and operating procedures of cooperatives. Of the 173 persons working at the Pavas Clinic, 156 are members of the Cooperative. COOPESALUD has a General Assembly which is comprised of all members of the Cooperative. By law, the General Assembly must meet at least once a year. COOPESALUD's General Assembly is reported to meet more frequently, at somewhat irregular intervals of roughly once every 3 to 5 months to be apprised of the status of the Cooperative and to vote on matters of broad policy.

The day-to-day operations of the Cooperative and the Clinic are primarily managed by the Administrative Council. The Council is comprised of 5 representatives and 2 alternates, all of whom are members of the Cooperative working at the Clinic. The general perception of many of the members of the Cooperative is that most of the major decisions involved in running the Cooperative are made by the Council and that its membership is restricted to the founding members of the Cooperative.

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The Administrative Council generally meets once a month. While the Council initiates most major decisions, in broad policy matters it generally must obtain the consent of the General Assembly. The General Assembly establishes the Cooperative's general internal rules and regulations, sets the broad parameters within which the Cooperative must function and, thereby, plays an important role in determining the potential efficiency and effectiveness of the Clinic.

### **Financing**

The initial two-year agreement between the Caja and COOPESALUD called for the Caja to pay the Cooperative 2,600 colones (about US\$33) annually for each Caja-insured resident in the service area of the Clinic. This figure is the Caja's estimated annual average expenditure per insured beneficiary of its Sickness and Maternity Health Program. In 1990, the Caja recognized that the Clinic's service area population had increased to 55,635 and that 96 percent of the population was Caja-insured. At that time, the Caja increased the per capita reimbursement rate to 2,760 colones. These changes resulted in COOPESALUD's 1990 subsidy increasing 29 percent in nominal terms and, in real terms, 14.4 percent. A new approach to determining the level of financial assistance from the Caja to COOPESALUD was established in June of 1991 and will become effective in fiscal year 1992.

For its part, the Ministry of Health (MOH) agreed to pay COOPESALUD a fixed

monthly sum of 1,375,000 colones. The Ministry, however, did not pay the Cooperative any portion of this agreed-upon quota, until September 1990, more than two years after the Clinic began operations. At that time, it paid COOPESALUD the equivalent of a single year's quota over a five month period and has not paid the Cooperative anything since.

Although the Caja does have a fee structure for uninsured persons and the MOH has a system of voluntary contributions for a relatively small number of specific services, COOPESALUD has decided that in the interest of maintaining equity in access to all services that it would not continue these practices. Therefore, the Pavas Clinic does not have any user fees.

Since its inception, Pavas has experienced a surplus in revenues. As a member of the Institute for Cooperative Development, Pavas is required to devote at least 30 percent of such surplus in improving the quality, or widening the range, of services provided and to retain at least 10 percent as working capital, leaving at most 60 percent which may be distributed among the Coop's members.

### ***THE COOPESALUD MODEL OF HEALTH CARE***

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In contrast to the passive, curative care model characterizing Caja service delivery, the COOPESALUD health care model is based on an outgoing, proactive approach of

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monitoring the health status of the community and bringing family and community health services to the people. COOPESALUD also performs the functions of the Caja service delivery system as a curative care provider, but its philosophy propels it to get much more involved in prevention and health promotion.

### **Philosophy**

The philosophy of the Cooperative concerning its role in the community is one characterized by a long-term perspective of a partnership in maintaining the health status of the community, but a partnership in which it is specifically charged with being the chief custodian of health. The view is that the Cooperative must attain an equilibrium between the economic interests of the organization and the social goal of the public service that it provides. If, it is maintained, the Cooperative does not provide efficient and effective services and does not develop an integrated model of care that has a perceptible impact on health status, then it will lose the favor and support of its users, and will compromise its future resources because it will confront increased demand for care from a less healthy population.

This philosophical view of the role of the Cooperative is well inculcated in members working in diverse capacities throughout the Clinic and appears to be the foundation of a spirit of community partnership and community service which is characteristic of many of the members of the Cooperative.

### **Service Delivery Strategy<sup>1</sup>**

When the Pavas Clinic first opened, it was greeted with great enthusiasm from the surrounding community. In part, this was due to the fact that an estimated one quarter of the Clinic's service population had previously been without access to care. The pent up demand of this component of the population, together with the elimination of all user fees and the increased physical proximity of a source of care, all contributed to the long lines.

Confronted with long lines, not wanting to begin the practice of refusing to see patients seeking care -- a practice common to the rest of Caja facilities -- and petitioned by representatives of other neighborhoods to establish a health post in their barrio, the Administrative Council soon decided to open additional facilities. To date, six community health facilities (Establecimientos Básicos de Atención Integrada -- EBAs) have been opened in the Pavas Clinic service area. Built upon the Pan American Health Organization model of Sistemas Locales de Salud (SILOS), the EBAs have proven a more cost-effective way of providing care, especially primary health care and preventive services.

An EBA consists of, at minimum, four persons -- a physician (who is a general practitioner), a part-time nurse auxiliary, a community health technician and a receptionist. COOPESALUD physicians permanently assigned to EBAs receive a 5 percent wage differential. The EBA is responsible for developing and carrying out the program of activities for its community,

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but also draws on the resources of COOPESALUD in carrying out its activities. The EBAs provide between 35 and 40 percent of all of the consultations provided by COOPESALUD, referring cases in need of more specialized attention, as well as those requiring lab work or x-rays, to the Clinic. In effect, the EBAs serve as the front-line actors for the Pavas Clinic in its areas.

Each EBA has begun its operations by providing curative care and performing a diagnosis of the community. They map out the area under their charge, which generally includes between 3,500 and 4,000 persons, and continually update these general frames of reference. Detailed profiles are kept of the current health status of patients, including vaccinations and the reasons for curative care visits. The EBAs actively monitor the health status of the local people and ensure that people in need of curative or preventive care are obtaining it. This model stands in sharp contrast to the Caja model, which is structured around the clinic where patients must be present if they are to receive attention.

Within the Pavas Clinic service area, there are 10 development associations, 8 health committees, and 12 committees and groups of volunteers with which the Clinic, and particularly the EBAs, work and coordinate activities. The EBAs work with these community groups in developing their annual plans, identifying and addressing new health problems and health needs as they arise, and coordinating with various non-governmental organizations working in the sector. Members of the Cooperative

also make regular presentations at the schools in its service area.

It was through these more formal mechanisms of community participation that the Pavas Clinic was petitioned to improve access to dental care. COOPESALUD responded by developing a mobile dental service which is based in a trailer which the Cooperative designed and had built expressly for this purpose.

### **Service Provision**

A comparison of the COOPESALUD Pavas Clinic with clinics of similar size and staffing patterns (known as Type 4 Clinics) yielded several findings.

#### **Service Provision**

Pavas accounts for a growing share of total Type 4 Clinic consultations although it is not the largest producer of consultations. In terms of the number of consultations provided, in 1990 Pavas exceeded the Type 4 Clinic average by 32 percent.

#### **Service Concentration**

Pavas provides more consultations per person to persons who have visited the clinic at least once; i.e., its concentration of services is higher. In 1989, the number of consultations per person consultation was nearly double that of the Type 4 Clinic average, and in 1990 continued to increase both absolutely and relatively, although at a much reduced pace.

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In part, Pavas' higher concentration ratio reflects the fact that the size of its service population is only about one-half that of the Type 4 Clinic average. Its higher concentration ratio is also a reflection of its relatively greater emphasis on, and provision of, preventive care. In a study conducted in November 1990 in which roughly 700 patients were randomly interviewed in Pavas and two matched control clinics (Moreno Canas and Solón Nuñez), 28 percent of Pavas' consultations were identified as preventive care. This contrasted sharply with the 2 to 3 percent of total consultations provided at the control clinics that were preventive ("Estudio Acerca de la Administración y la Utilización de Servicios de Salud en la Clínica de Pavas," 1990).

Although there is no Pavas Clinic data on the cost of first visits relative to subsequent visits, studies performed in other countries have found that first visits are relatively more expensive to provide. A first-time patient requires additional "work-up" procedures for the physician to become adequately familiar with the patient. This is likely to involve more physician time and more ancillary services, both of which drive up costs.

The holistic approach to medicine practiced by COOPESALUD means that when an unfamiliar person comes for service, it will probably take the COOPESALUD physician longer relative to a Caja provider to become familiar with the case because, in addition to the physical ailments, the COOPESALUD physician is more likely to solicit information about the patient's environment. Thus the Coopesalud physician's approach

to medicine is likely to mean higher costs for a patient's first consultation.

At the same time, because Pavas permanently assigns its physicians to particular geographic areas so that they can become more familiar with the environment in which their patients reside, it is likely that these first visits are not as expensive to produce as they might be in the absence of such a policy.

It is also important to note that the assignment of physicians to particular neighborhoods through the EBAs is a desirable practice because it provides greater continuity of care for patients. Not only does the physician become more knowledgeable about his/her patient's environment, but he/she also becomes much more familiar with individual patients. This type of continuity of care is regarded as one of the most important process indicators of quality of care. Furthermore, the high level of utilization of persons who have visited the clinic at least once is manifest of their satisfaction with and confidence in their Pavas provider. While Pavas patients can request another physician if they find the one they are assigned to unacceptable, this has only very rarely happened.

### Physician Productivity

Pavas has steadily increased its number of physicians as well as its number of physician hours. At the same time, physician productivity has also increased. In 1990, Pavas physician productivity surpassed the Type 4 Clinic average by 9 percent. Increasing productivity means decreasing

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unit costs of production. With personnel costs constituting 70-75 percent of total consultation costs, increasing physician productivity has resulted in a decline in the average (real) cost of a consultation.

### Use of the Emergency Room and Access to Care

Pavas has provided a rapidly increasing number and share of all Type 4 Clinic emergency consultations. According to the Pavas Administrator, however, only about 30 percent of what it reports as "emergencies" are in fact emergencies. The bulk of services provided by the Pavas emergency room are non-emergency ambulatory consultations provided after the main clinic has closed its doors for the day. In response to its perceptions of the community's need to have greater access to care during non-traditional hours, COOPESALUD maintains an emergency room which is open an additional 3 hours every evening. Unlike other clinics, Pavas Clinic emergency room physicians are directed not to turn away any patients, which often means they work well beyond the 7:00 pm closing time.

### Dental Services

Pavas' provision of dental services has grown dramatically in both absolute and relative terms. Dental services increased nearly six-fold from 1988 to 1989, and expanded by yet another 23 percent in 1990 when they numbered more than 27,000; accounting for about one-sixth of all Pavas consultations. According to the Clinic Administrator, COOPESALUD has

expanded its provision of dental services significantly relative to what is the norm in other Type 4 Clinics in response to community requests.

According to the Caja, in Type 4 Clinics it costs approximately half the amount of money to produce a dental consultation as that required to provide a general consultation. The fact that over the past 3 years Pavas' service mix has become more dental care-intensive together with the fact that it is providing a growing share of these less expensive (but not less important) consultations, has contributed to Pavas' ability to maintain lower average consultation costs than other Type 4 Clinics.

### Physician Specialist Consultations

In keeping with its prevention orientation, the Pavas clinic has consistently provided fewer specialty consultations relative to general medical consultations than other Type 4 Clinics, though the magnitude of the differences is small. According to the Caja, a general medical consultation in a Type 4 Clinic costs roughly 80 percent of what a specialist consultation costs. Pavas' relatively greater provision of general medical consultations, therefore, is another contributory factor (albeit a minor one) in its lower average (overall) consultation cost.

### Hospital Referrals

Another source of reduced costs attributable to COOPESALUD is its much lower rate of referral to higher tiers of more expensive care. A study of referral rates to the

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National Children's Hospital found that the Pavas Clinic referred significantly lower numbers of children relative to other Type 4 Clinics. The economic and medical outcomes of these cases need to be assessed, for they too add to the cost savings attributable to COOPESALUD.

### **Minor Surgical Interventions**

Relative to the other Type 4 clinics, since its inception Pavas has had relatively fewer minor surgical interventions and treatment procedures. (Note: Major surgical interventions are not performed at Type 4 clinics.) Pavas' lower rate of surgical procedures is another reason that its costs per consultation are lower than the Type 4 Clinic average.

However, much of the difference between the Cooperative and the Type 4 Clinics' average number of minor surgical interventions may be due to differences in reporting. Many of the procedures performed in Pavas which could be regarded as minor surgical procedures (e.g., lancing a boil) may not be reported as such.

### **The Cost of Services Provided by COOPESALUD**

Based on the financial reports that each of the Type 4 Clinics submits on a monthly basis to the Hospital Costs Section of the Accounting Department of the Caja, the average cost of a consultation provided by COOPESALUD is about 30 percent less than one provided at traditional Caja clinics of the same size and staffing pattern (see Figure 1). While this source of data

provides for the most directly comparable costs between Pavas and other Type 4 Clinics, it should be noted that the methodological approaches adhered to by the clinics in reporting these data are not universally consistent. Notwithstanding, since unit costs are the single best measure of efficiency, it can be concluded that cooperative model approach to Type 4 Clinic administration and care provision provides the most efficient use of Caja financial resources.

## ***STAFFING AND ADMINISTRATION***

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### **Staffing**

Most of the members of COOPESALUD are either former or current employees of the Ministry of Health or, more commonly, of the Caja. Turnover of personnel at Pavas is reported to have been very low since its inception.

The staff identify several reasons why they have found working at Pavas both appealing and rewarding. Principal among these are higher pay, the Clinic's more personal administrative structure, and the satisfaction of having some say in how the Clinic is administered. Although the Clinic Administrator explained that with a low staff turnover, there has been no need to formally develop and delineate explicit personnel selection criterion, he also noted that technical competence has to date only been part of the COOPESALUD hiring process. In addition to administering an examination

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which tests the applicant's technical knowledge, at least as important a part of the personnel selection process is a personal interview, and, during the first few weeks of tenure of a new employee, observation of him/her on the job.

Another important factor differentiating COOPESALUD staff from Caja staff is that they are generally paid more, however, a comparison of the salary levels of COOPESALUD and the Caja staff is not a straightforward undertaking. A significant proportion of the remuneration in both organizations, especially that of physicians, is dependent upon the individual's years of service with the organization and, to a lesser extent, the specific conditions in which he/she works. In the beginning years of service, COOPESALUD salaries average about 10 percent greater than those of the Caja. This difference narrows as the number of years of service increases. (As already noted, COOPESALUD members are also eligible to receive a portion of any excess revenues which the Cooperative might accumulate over the course of the fiscal year.)

An applicant's philosophy of medicine, particularly his/her interest in practicing holistic health care and in promoting preventive care is another important factor, and one that enters the personnel hiring process in two different ways. First, this is clearly the preference of the Administrator and the COOPESALUD model of health care; they look for individuals with similar interests and commitments. Second, it is likely that individuals who share these preferences and commitments self-select and

apply to work with COOPESALUD. The fact that personnel turnover is so low is probably a good indicator that staff expectations coincide closely with their actual experiences, and, as a result, staff satisfaction is high.

The number and mix of COOPESALUD personnel are similar to other Caja clinics, with the exception of administrative staff and auxiliary technicians. The Pavas Clinic's use of fewer administrators and more personnel who contribute more directly to the provision of additional health care services -- as well as to maintaining a better organized and more efficiently functioning clinic -- has contributed to the higher level of productivity of Pavas, which, in turn, has contributed to its lower unit cost of providing a medical consultation (see Figure 2).

### **Administration**

For the most part, the Cooperative has simply adopted the administrative systems of the Social Security system, with which most of its personnel -- as former Social Security employees -- are familiar. There have, however, been some innovations in administrative procedures such as the development of an electronic inventory valuation and control system, the pharmacy's daily log of the stock and flow of certain pharmaceuticals, and an electronic patient registry file which eases what was formerly a lengthy registration procedure with long waiting lines.

The Cooperative has not introduced fundamental changes in either the

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composition of personnel nor in the structure of its personnel system. In fact, it utilizes the Caja's own personnel manuals and has maintained the Caja's job descriptions, job titles, and pay scale.

Until January of 1991, the Coop's financial system consisted simply of income and expenditures accounts, without assigning costs to specific cost centers. Under pressure from the Caja, COOPESALUD has introduced a system using the same cost centers the Caja has used for more than a decade.

Starting in 1990, COOPESALUD began programming its service goals on an experimental basis. The system consisted of making estimates of the expected level of service provision for each of a number of different types of activities broken down by type of clientele. The program plans of these distinct entities is then aggregated to generate the Coop's annual plan.

To date, the clinic has not estimated its human resource requirements for each type of activity. The Administrator of the Clinic maintains that the Cooperative needs to first develop some baseline service provision data before it can plan input requirements with any acceptable degree of certainty -- it simply has not been worth the effort to plan resource needs before this time. It warrants pointing out that the members of COOPESALUD have had to invest or otherwise risk almost none of their own money in this venture, and that the level of support provided by the Caja has apparently been more than adequate. Had these conditions been otherwise, the value of this

resource planning activity -- and that of other cost-monitoring administrative procedures, as well -- might be more developed today.

### ***RESULTS IN PATIENT SATISFACTION AND FINANCIAL SUCCESS***

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#### **Patient Satisfaction**

National household surveys have found that between 25 and 40 percent of Costa Ricans are dissatisfied with various technical, personal and administrative aspects of the care they received at Social Security facilities. In surveys of patient satisfaction with the Pavas Clinic, respondents indicated high rates of approval of the care and treatment they received. About 95 percent of women 20 to 40 years old interviewed reported being satisfied with Pavas Clinic services. An even higher rate was reported among the elderly sample.

In contrast, a patient satisfaction survey of a Type 4 Clinic which is very similar in setting, service area population and staffing to Pavas found less than half of the Clinic's clientele were satisfied with most aspects of the care they received. In a review of these and several other patient satisfaction surveys, a December 1990 document of the Caja concluded that the Pavas Clinic has:

- A high level of general patient satisfaction (around 95 percent).
- Adequate physician-patient relations.

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- Very favorable opinions about support services, such as x-rays and laboratory services (96 percent) and pharmacy services (90 percent).
- A significant reduction in the waiting times and favorable opinions about the actual time waited.

### **Financial Success**

There can be little doubt that COOPESALUD provides health care services at a significantly lower cost relative to a traditional Caja clinic. In fact, COOPESALUD provides care at about 70 percent the cost of a Caja-run facility.

All of the cost savings attributable to COOPESALUD have yet to be fully identified. For example, COOPESALUD has generated additional cost savings by reducing the number of patients who subsequently have to return for treatment (which requires time away from productive activities), or who then go without treatment and require greater medical care in the future.

What makes the economic and financial savings of COOPESALUD perhaps somewhat less promising has to do with the method which has been adopted to determine the level of financially remunerating the Cooperative. To date, the Caja has not opted to try to reduce its total outlays, but rather has tried to get more health care services for a given outlay (i.e., to improve efficiency). With increasing pressure on the Central Government to reduce expenditures,

the Caja should also focus on developing new financing arrangements which encourage the Cooperative to reduce overall expenditures.

Another major contributing factor to COOPESALUD's cost-effectiveness has been its restriction of care to its assigned service area population. Caja patients commonly seek care in Caja clinics other than the one nearest their residence. This practice is generally not problematic from a general Caja financing perspective, since the funding of individual traditional Caja clinics is not strictly tied to the size of the clinic's service population. Such is not the case, however, with the COOPESALUD Clinic. To the extent that COOPESALUD uses its resources to provide care to other than residents of its service area, it dissipates the availability of resources with which to care for the specific population within its charge.

To deal with this situation, Pavas has instituted a practice of discouraging people who live outside of its assigned area of influence (insured or otherwise) from obtaining care at the clinic. Such persons are not denied service, but it is explained to them that the Caja provides resources to another clinic in order to provide them with care and that they will not be treated at Pavas if they should seek care at the clinic in the future. The issuance of this warning to the patient is then indicated on the patient's clinic registration card. A single warning usually proves effective in discouraging non-residents from returning. As a result, there has been a dramatic reduction in expenditures on medications,

x-rays, and laboratory examinations. For example, the value of medications provided to non-residents constituted 14 percent of all medications distributed in 1988. This share was effectively eliminated by 1990.

***ISSUES FOR FUTURE DEVELOPMENT OF THE PAVAS MODEL***

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There has been considerable growth and maturation in the managerial systems of COOPESALUD throughout the course of the organization's three-year life. Still, COOPESALUD needs to undertake a number of difficult and relatively complex managerial steps in order to improve its financial controls and thereby the efficiency with which it operates. These include:

- Integrating its purchasing and cost information systems.
- Institutionalizing annual program planning by each department.
- Devising a system to provide at least quarterly, and preferably monthly feedback meetings of progress towards the goals set out in the annual program plan.
- Developing input/supply requirements (personnel time and materials) for each department and then tying these directly to the programmed/planned service delivery level of each department.

- Developing individual department information systems which will be integrated to produce monthly activity reports.
- Developing individual department cost data on a service-specific basis which will provide the link between annually and monthly programmed/planned activities/services and their financial requirements.

**Public Policy Issues**

The cooperative-based alternative model has great potential and there is growing interest on the part of providers to work in such systems. Despite the fact that the Caja has assumed a very low profile with respect to the development of this alternative model of care and has not publicly expressed interest in further such experiments, the Caja has just recently received four additional proposals for developing cooperative-based clinics. The need exists and the interest is there.

However, the Caja needs to determine whether, in addition to cost-effectiveness, it should give greater weight to the Cooperative achieving certain financial goals and objectives and if so, how that is to be accomplished. For example, the Clinic has not yet instituted some form of cost recovery which would limit the unnecessary use of services. With no connection between patient payments and the amount of services rendered, there is little incentive for patients to limit their number of

consultations.

Another public policy issue to be addressed is how to continue working with the health sector unions. One option is to continue the present course of piecemeal reform. Avoiding making explicit and significant changes may be the most sure way of being certain that such reforms are not derailed by the opposition of unions and others who view these changes as threats. By the same token, however, maintaining a program of reform as slow as the current process may prevent it from ever being able to significantly change the system. To accelerate the process of change will require changes in some of the laws which discourage implementation and replication of the cooperative model and preclude it from being able to generate significant changes in the system.

Additional consideration should also be given to developing a formalized program of technical assistance. Such a system might include having the older models help pass on their "lessons learned" to new players. The objective of such a program would also be to strengthen and accelerate the reform process.

At a minimum there is a need for policy makers to explicitly identify the goals of the Caja's alternative models so as to aid in the development of more specific evaluation criteria. More specifically, there is a need to develop a more structured approach to alternative models, including:

- Developing explicit, commonly recognized evaluation criteria and

indicators by which to assess existing models. The Caja evaluation unit's recent development of a minimal set of alternative model proposal requirements is an important first step in this direction.

Policy-makers should provide more explicit goals and parameters for alternative models in order to eliminate the ambiguities and uncertainties which currently plague the programs and the Caja technicians in charge of overseeing them.

These are some of the steps which are necessary at this juncture if the models are to be encouraged, or even allowed, to develop to their full potential.

### ***LESSONS LEARNED***

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COOPESALUD is an alternative model of health care which has a plethora of diverse goals and objectives. By many criteria, the Cooperative Model of care provided by COOPESALUD at the Pavas Clinic has been highly successful. These criteria include:

- patient satisfaction
- greater access to care
- the level of service provision
- the level of coverage of the service

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- area population
- the concentration of services
- the mix of services provided (preventive versus curative)
- the apparent continuity of care
- the responsiveness of the Clinic to the health needs and stated desires of the community

COOPESALUD has also indicated that it can provide quality services at a lower cost than other clinics. The potential for reducing public funding would be even greater with the introduction of a cost recovery scheme.

One of the most important factors in COOPESALUD's success is the linkage between physicians' salaries and the number of patients served. In that way, physicians are motivated to work efficiently in order to see the greatest number of patients possible and to demand efficiency from their staff as well. An added performance incentive is the distribution of the surplus among Clinic staff. These factors, combined with the Clinic's participatory management style, have resulted in maximizing the effectiveness of the Clinic's human resources and reducing the costs associated with high staff turnover.

In addition, there is greater assurance of quality of care since physicians have a vested interest in maintaining patients and not having dissatisfied patients who will switch to a different physician. At the same time, COOPESALUD has institutionalized continuity of care by having patients see the same physician. Thus, physicians are allowed to follow the health progress of patients.

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1. Unless otherwise stated, all data cited are from the Anuario Estadístico, Caja Costarricense de Seguro Social, Presidencia Ejecutiva, Dirección Actuarial y de Planificación Económica, 1988, 1989, 1990.