Introduction

As contracting out for health service delivery is increasingly seen as a strategy to increase efficiency and improve quality in service delivery by governments, the role of the public sector in setting performance objectives and monitoring contracts has become instrumental in the success of contracting. This article examines and analyzes the experience of the Costa Rican Social Security Fund (CCSS) in monitoring and evaluating its contracts for primary health care (PHC) service delivery. It discusses the experience of COOPESALUD, a Costa Rican cooperative in the Pavas district of San Jose that has been under contract with the CCSS since 1997.

COOPESALUD is an employee-owned cooperative founded in 1987. In 1999 it had 189 workers of which 15% were administrative staff. COOPESALUD is governed by a seven-member general assembly. Six commissions form and provide guidance to COOPESALUD’s activities: education and social welfare, surveillance, general management, health services, quality assurance, and administration. A though COOPESALUD has contracts with the CCSS for specialty services and ambulatory surgeries as well as PHC services, this article focuses only on the CCSS’s evaluation of its 1998 contract with COOPESALUD for PHC services.

Given the importance of contractor monitoring and evaluation, the public sector needs the capacity to choose indicators and measure contract performance. Contracting for service delivery is not a solution to weak public sector management; rather it places new demands upon government managers, which, although distinct from direct service provision, require management and supervisory skills. As seen in the case of Costa Rica, governments need to develop systematic monitoring and evaluation systems as well as strengthen the skills of public sector managers to accurately monitor contracts and check performance. In the case of the CCSS, the government has had significant success in developing an evaluation system.

This article lays out a framework for analyzing contract evaluations. The contract between COOPESALUD and the CCSS is then analyzed in terms of what indicators for measuring performance are contained in the contract, the results of contract evaluations, and how the contract indicators and the evaluation results fall under the framework presented.

Background

In order for contract implementation to meet the objectives of the contract, the contract needs to specify how performance will be monitored, including specification of target indicators.
Monitoring and evaluation in contracting out

indicators, as well as how contractor payment will be affected by performance. Both the literature and experience on monitoring and evaluation of contract performance in developing countries is scarce. Research on contracting of ancillary services and health service delivery has shown that monitoring of contractor performance is frequently non-existent or poorly done. For instance, in research conducted on ancillary services in Bombay, Papua New Guinea, South Africa, Thailand and Zimbabwe (Mills 1998), the responsibility for supervision and monitoring of contract performance was not clearly defined in the contract by the health authorities. In a review of contracting experiences for both clinical and non-clinical services in developing countries, Mills states that contract terms rarely include sufficient specifications or allocation of responsibilities to allow contract monitoring (Mills 1997). Results of a 1995 evaluation of South Africa’s experience in contracting with for-profit contractors for hospital services found limited specification of contractor obligations and a lack of detail on how performance would be monitored or penalties applied for under-performance. This evaluation demonstrated that these deficiencies resulted in an inefficient use of public resources (Broomberg 1997). The more highly specified the contract in terms of performance expectations and monitoring, the less the risk to the purchaser.

There is a tendency on the part of the purchaser to neglect construction of systematic contract performance measures. Experience has shown, in many developing countries, a trend towards public sector contracting-out for services as a response to ineffective public sector capacity to deliver those same services. This may be one of the reasons why public sector purchasers generally neglect to incorporate performance measures into service contracts.

In a recent study conducted under the Partnerships for Health Reform (PHR) Project (financed by the United States Agency for International Development) in the Latin America and Caribbean (LAC) region, on the experience of not-for-profit, non-governmental organizations under contract by the public sector for service delivery, Abramson showed that very little is being done systematically in monitoring and evaluation of health service-delivery contracts (Abramson 1999). It was clear from the cases examined in the study that information systems and monitoring and evaluation are areas that could be strengthened. Few countries in the LAC region have developed a monitoring and evaluation system for service delivery contracts. Those that have developed such a system do not systematically incorporate information gathered during evaluations into either restructuring of existing contracts or negotiations of new contractual agreements. During the PHR study, Costa Rica stood out as the most advanced in terms of monitoring and evaluation of contracts.

The Costa Rican Ministry of Health is responsible for oversight, regulation and strategic management of the health system. The Costa Rican Social Security Fund (CCSS) is responsible for service delivery. It provides coverage to 90% of the population and is financed through tripartite compulsory contributions. Employer contributions constitute 9.25% of all salaries for a total contribution of 15.25% from formal sector payroll. Care for the poor is subsidized entirely by the State. The CCSS is mandated to cover 100% of the population (PAHO/WHO 1999), but a small sector of the population uses private health services, whose supply has increased in recent years.

The recession of the 1980s caused the Costa Rican government to look for innovative ways to reduce public expenditures. In the social sector, the CCSS supported the formation of COOPESA LUD, a cooperative owned and run by former CCSS employees in the Pavas District, an underserved peri-urban area outside the capital. Through partnership between COOPESA LUD and the CCSS, the Costa Rican authorities hoped to cut costs and increase coverage to underserved populations. COOPESA LUD formalized its partnership with the CCSS in 1988 through an agreement to support the Costa Rican PHC model by providing services that emphasize coverage, accessibility, efficiency and quality of care. COOPESA LUD rents its installations from the CCSS. In 1998 it signed its first performance contract called a compromise de gestion with the CCSS, whereby contract deliverables as well as parameters and mechanisms to evaluate contract compliance were negotiated and agreed upon. The Costa Rican government, through the CCSS, monitors contracts and exercises its regulatory functions in relation to health care quality; in particular by performing 6-month assessments of COOPESA LUD’s contract performance (Abramson 1999).

Framework

This section lays out a framework for determining indicators and defining criteria under which to analyze them (Box 1). It is designed to set performance goals and measure them against national standards. Prior to assigning indicators to measure performance under a contract, the purchaser should clearly lay out the objectives of the contract. The indicators contained in the contract should be directly related to the stated objectives of the contract.

**Box 1. Monitoring and evaluation framework**

| Indicators related to purchaser's objectives |
| Baseline data available |
| Rewards related to positive performance in relative terms |
| Supervision and monitoring plan in place |
| Indicators meet criteria |
Indicators must be objective, quantifiable, easy to measure (i.e. lower administrative burden on the purchaser), and monitoring or processes that the contractor can directly influence. Performance indicators should be directly related to the purchaser’s contracting objectives. So prior to determining monitoring and evaluation. The contract terms should also include supervision and contract performance criteria.

Once a baseline is determined, the purchaser will have something against which to measure contract performance. It is therefore essential that the purchaser assess planned gains in quality of care, expansion of coverage or potential savings prior to entering into contract negotiation and determining contract performance criteria.

The contract terms should also include supervision and monitoring of the contract, as well as an evaluation plan. The contract must state who is responsible for supervision and monitoring of the contract, as well as the frequency of contracting monitoring and evaluation.

Knowles and Leighton2 contend that prior to determining which indicators should be used to measure health system performance, health authorities need to hold an internal discussion as to what indicators will be used to measure progress, and what criteria will be used to evaluate each indicator (Knowles and Leighton 1997). Once criteria are set, each of the criteria should be weighted in order to determine their importance to the overall indicator.

In the case of government purchasing of health services through contracts, the same discussion should take place prior to entering into contract negotiation. It is preferable that indicators be expressed, when possible, in relative terms (percentages or ratios) rather than in absolute terms (raw numbers) in order to facilitate comparability. For example, if increased coverage is the objective, and the baseline is 62% of the target population and future target is 80%, we are looking at an increase of 18 percentage points. Now if actual performance under the contract is 76%, the contract should reward an increase of 14 percentage points (76–62 = 14). In other words, the contract should not penalize for the 4% percentage point shortfall (80 – 76 = 4). In this way good performance is encouraged. Indicators should not be simply directional (e.g. “increase in number of patients seen for acute respiratory infection”). They should be based upon empirical evidence and be set through baselines, benchmarks and targets agreed upon between the purchaser and provider prior to contract signature.

Performance indicators included under the terms and conditions of a contract act to ensure the provider’s responsibilities to the purchaser. Ideally, the indicators will be straightforward and measured easily at low cost. During the contract design phase (or redesign in the case of a renegotiation based upon performance evaluation results) the objectives or reasons for contracting need to be clearly identified. A definition of the services to be contracted needs to be included in the contract and indicators for measurement of contractor performance and targets should be identified. In addition, the contract should contain a supervision and monitoring plan as well as specifying the frequency of evaluations and responsibility for these functions. And lastly, the linkage between payment and performance should be set out under the terms of the contract. Bearing this in mind, the purchaser should ideally allocate enough resources to ensure proper monitoring and evaluation of contract performance.

Case study and contract analysis

This section analyzes the contract with COOPESALUD, including the objectives of the contract, performance indicators, criteria for evaluating indicators and how payment is related to performance.

As a response to the recession in the 1980s, public expenditure on health was frozen in Costa Rica. In order to curb rising health care costs and to reduce public health expenditure, the CCSS developed its first comprehensive and integrated PHC strategy in 1988. One of the components of this strategy was to reach an agreement with COOPESALUD on PHC service delivery under the assumption that agreements with non-public sector providers would be an efficient way to curb costs and extend coverage. Later on, contracting expanded in Costa Rica as a strategy to extend the availability of health care providers to cover the unmet needs of target populations.

In 1997, under Costa Rican health sector reforms, these contracts were formalized as a strategy to improve quality of care, increase coverage and reduce costs. The CCSS contract objective, as stated in the 1998 contract with COOPESALUD, is to provide integrated health care services which are equitable, opportune, effective, efficient and of quality to a specified target population. This population is defined by the number of persons located in a geographic area, divided by each of Costa Rica’s five PHC programmes (CCSS 1998).

The contract objectives are very clearly defined in the contract. Among these are five specific objectives: to satisfy the health needs of the population; to improve access to health care for the target population; to gain knowledge of user opinions on health care services and establish strategies to improve user satisfaction; to optimize the effective and efficient use of health service delivery resources; and to work for the benefit of the individual. These objectives are broken down into three main categories: organization,
service delivery and quality of care. These objectives are very
detailed and set out in the body of the contract. In direct agreement with the 1998 COOPESA LUD contract's
stated objectives, three categories of performance indicators
are defined under the terms of the contract: organizational,
qualitative and those related to direct service provision.
Table 1 presents selected indicators from each of these three
categories, the agreed upon goal of each, sample criteria used
to evaluate them, and the actual evaluation results from the
1998 COOPESA LUD contract. Percentages given for goals
reflect a percentage of the total target population intended to
be reached. The column for "evaluation result" indicates the

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<th>Table 1. Sample indicators from the COOPESA LUD contract for PHC service delivery: targets versus results</th>
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PHC = primary health care; R H = reproductive health; FP = family planning; OB/Gyn = obstetrics and gynaecology
percentage of the ‘goal’ actually attained. This comparison between ‘goal’ and ‘evaluation result’ makes sense when setting goals for service delivery indicators. However, measurement of ‘organizational’ or ‘quality’ indicators through a ‘goal’ of ‘yes’ or ‘no’ are more difficult to quantify with a percentage result if the goal is not stated as a percentage (see Table 1). The evaluation results will be discussed in the following section.

The first group of indicators is ‘organizational’ and it is compulsory that the contract comply with these standards. This group of indicators is set beforehand by the purchaser and is binding on the provider. In order to facilitate measurement of these indicators they are rated with either a ‘yes’ or ‘no’ status (see Table 1 for examples).

The second group of indicators is for service delivery. Service delivery indicators are quantitative and are set out in terms of the percentage of the population to receive services (either curative or preventative) and can be measured on a continuous basis. Service delivery percentages are based upon number of visits. Each visit must fulfill a set of minimum criteria (see Table 1 for examples).

Service indicators are broken down into six target populations that correspond to Costa Rica’s PHC model. The contract states that COOPESA LUD must meet these indicators for integrated PHC provided to five target population groups: children, adolescents, women, adults and the elderly. For each indicator, a target is set in terms of the percentage of the target population that should receive the specific services. In order to calculate total annual coverage (for the service delivery indicators), the CCSS estimated the total number of first time visits to a particular programme and divided this figure by the target population. Then, to calculate attainment of these goals, this figure (initial coverage) was then multiplied by the percentage of patient files in a sample that met the minimum criteria for each indicator. Estimated annual coverage could then be determined. For example, estimated annual coverage for children under 1 year of age is calculated through both record review and as a percentage of patient files that show compliance with criteria for that indicator.

As another example, the contract stipulates that for the reporting period, prenatal care coverage must be provided to at least 90% of the target population. It is unclear, however, what the exact target population is. According to the population chart in the contract, in 1998 the target population of women aged 15–45 years (childbearing age) was 20,891. Although this number can be deduced from the number of women who fall within this age group, the indicator for prenatal care in the contract does not stipulate a specific number of cases to indicate how many women this includes. It is also unclear as to whether the entire population of women of childbearing age is the target or whether a calculation was performed to indicate how many of these women would likely become pregnant during the year. The significance of this data will be discussed in the following section where the results of the evaluation are analyzed.

In addition, there are the ‘criteria’ of quality for each of the services (indicators) that indicate the clinical protocols to follow for each (see Table 1 for examples). For example, for the indicator of coverage of prenatal services, criteria include a minimum of five prenatal visits for a full-term pregnancy, identification of pregnant women in their first trimester of pregnancy, identification and classification of risk in accordance with national norms, identification of sexually transmitted diseases, etc. In accordance with national norms, the indicator for coverage of infants from 0-12 months requires that all patients are classified by risk and receive iron supplementation from 6-12 months (see Table 1 for further detail).

The next section will discuss and analyze COOPESA LUD’s success in meeting these criteria and the target population agreed to under contract.

The third category of indicators is quality of care. The COOPESA LUD contract measures quality of care in terms of opportunity, continuity, adequacy, accessibility and user satisfaction. These indicators are based upon effectiveness and productivity criteria. However, nowhere in the contract are these terms defined. Like the organizational indicators, the quality indicators are also rated with either a ‘yes’ or ‘no’ and are subject to negotiation between the purchaser and contractor prior to contract signature. An attempt is made to quantify quality indicators ranked with a ‘yes’ or ‘no’ rating through assigning a percentage for attainment for each indicator. If ‘effectiveness’ is defined as the resolution of a problem or the outcome of a treatment, and ‘productivity’ as the number of visits or volume of services provided, then the ‘yes’ or ‘no’ ratings make it difficult for the evaluators to determine what the actual level of effectiveness and productivity are for each indicator.

In terms of links between performance and rewards, the contract not only contains a fully developed list of indicators for gauging contractor performance, but stipulates that overall results from a 6-month evaluation inferior to 90% of the agreement would have a direct and proportional impact of up to 2.5% on the budget available for the following 6 months. Thus the following semester’s budget would be reduced accordingly. Also, under the section on economic conditions the CCSS reserves the right to conduct periodic audits of the contractor use of equipment, infrastructure and materials including medical supplies and medicines. It stipulates that lack of compliance with the agreed upon level of materials and equipment could be cause for termination of the contract.

The contract includes an evaluation protocol that defines who will evaluate the contract, the frequency of evaluations, data sources for the evaluation, and how the results will be used. Although the contract does provide for evaluations of contractor performance every 6 months, it does not include any systematic supervision and monitoring plan within the language of the contract. Neither does the contract directly state how the results of evaluations will be used to renegotiate future contracts.
Evaluation methodology

The 1998 COOPE SALUD contract was evaluated by staff from the A dministrative D ivision of the H ealth Service P urchasing D epartment of the C CSS. O rganization, service delivery and quality of care performance under the 1998 contract were evaluated by a multidisciplinary team including representatives from the E valuation C ommission. C CSS regulations state that the E valuation C ommission, comprised of members of the C CSS, may also include a member from the health care provider under evaluation, in this case COOPE SALUD. Indeed, representatives from COOPE SALUD’s management team did elect to participate in the evaluation of the 1998 contract. The evaluation team carried out an assortment of activities including analyses and adaptation of data collection instruments being utilized routinely by COOPE SALUD, development of new data collection instruments, and analysis of routine data collection results. Select interviews and focus groups were also conducted as part of the evaluation in order to complement routine data collection done by COOPE SALUD with missing information.

Evaluations are conducted every 6 months. Information sources include interviews, site observation, provider reports related to the indicators contained in the contract, data generated electronically and any other pertinent information that may be available at the time of the evaluation. Data is processed in EPI-INF O version 5 for SPSS Windows.

Evaluation results

Based on the framework described earlier this section discusses the evaluation results. It then analyzes to what extent the contract includes indicators that measure whether contractor performance meets the C CSS’s stated objectives, how actual performance compares with contract objectives, and how useful this information is to the purchaser in measuring performance.

Service delivery

For calendar year 1998, the evaluation results under the service delivery category reflected a total scoring of 86%. A lthough the contract terms do not specify what percentage is assigned to each of the criteria evaluated under each indicator, the evaluation does weight each criterion.

The indicator for growth and development for children less than 1 year of age, along with some of the quality criteria to measure this indicator, are analyzed here. This childhood growth and development indicator represents only 2% of the 60% score for service delivery. The evaluation terms of reference state that for this indicator four out of six criteria must be met.

A lthough total coverage reported for this indicator reached 100%, based upon the data analyzed, only 50% of the cases were included (versus the 90% target) complied with four of the six criteria established in accordance with the norm (see Table 2). T here are two issues coming into play here; the first relates to coverage and the second to performance as measured by compliance with quality criteria.

The issue of coverage scores above 100% relates directly to provision of incentives to providers for good performance. Coverage scores are calculated by the C CSS based upon a maximum possible score of 100%. T he C CSS e valuation report states that any percentage points above 100% reflect a problem in the definition of the target population. We can infer from this practice that the C CSS does not intend to reward the contractor for exceeding population-based targets.

Regarding compliance of quality criteria, by accepting compliance with four out of six treatment criteria, the purchaser is in essence lowering the acceptable standard. We can infer then that the criteria of quality are not essential to determining rewards or penalties for performance. It is recommended that incentives be created to go beyond contract targets and improve upon performance by either exceeding the target coverage or improving upon the quality of care by meeting all of the criteria stipulated under the contract.

Next we will examine two of the criteria for the indicator of growth and development coverage for children aged under 1 year: postnatal care in infants less than 28 days old and screening of neonates less than 7 days old. The 1998 contract estimates the target population for infants under 1 year to be 1315 for that same year. T he evaluation results found that 74% of infants less than 28 days old attended the clinic and 100% of neonates less than 7 days old were screened (see Table 2). T he contract does not, however, state the estimated number of infants less than 28 days old or the number less than 7 days old. N or does the percentage covered tell us if this 100% compliance with the <7-day-old screening criteria represents the total target population of under-ones. Or rather are we looking at 100% of the 74% of children seen at less than 28 days of age? I f the latter is the case, then has COOPE SALUD really reached the target for meeting the screening criteria? I s it clear what the target really is?

The contract includes pre- and post-natal care as well as care of the newborn, but it does not include actual deliveries. T herefore there appears to be little incentive for COOPE SALUD to bring women in for deliveries; and women are delivering babies elsewhere, either in the commercial sector or through C CSS facilities. T his would make it harder for COOPE SALUD to reach the newborn population. Care
must therefore be exercised when setting utilization targets for indicators such as care of newborns or pre- and post-natal care. The target would be better set based upon the expected population who will actually be seeking the COOPESA LUD services included under the contract, rather than the entire geographic population.

Quality

Lack of baseline data and use of ‘yes’ or ‘no’ scoring to measure performance of quality of care is not very precise. The ‘yes’ or ‘no’ scoring tells the evaluators very little in terms of the extent to which progress has been made. Discussion of these quality-of-care indicators and suggestions for a more quantitative approach through the examples of user satisfaction and waiting time will be analyzed here.

The application of user satisfaction surveys is given a ‘yes’ or ‘no’ score in the evaluation. This score, however, does not provide information on the results of the application, nor what categories are included in the user satisfaction survey. The following are some suggestions for improving measurement of performance through user satisfaction surveys. If the CCSS wishes, for example, to reduce waiting time, increase medical supply and medication stocks, and improve interpersonal relations between provider and end user, then the survey instrument should be crafted to include questions on each of these themes. This survey instrument should be included in the contract. Once the categories to be surveyed are agreed upon, then the purchaser and provider could set goals to incorporate survey results into facility operations. A benchmark could be set such that results from one out of two of these categories must be operationalized after the first 6 months of the contract, and from two out of three categories at the end of 12 months. If, for example, COOPESA LUD demonstrates during the evaluation that results from patient satisfaction surveys in all three of these categories obtained were acted upon, then the contractor would be rewarded for exceeding the target. However, if only one of these three categories is improved upon at the end of 12 months, then a penalty would be applied. In order for measurement of this indicator to be most effective, the CCSS would have to have gathered baseline data through an initial user satisfaction survey prior to or upon contract initiation.

Another indicator listed under the quality category is an analysis of waiting time. Through a ‘yes’ or ‘no’ score the purchaser gets no sense of what type of analysis has been conducted or whether results of this analysis have been incorporated into facility operations. Nor does the purchaser have any idea what the actual waiting time is, or if it has changed. There is no reward for a shorter waiting time, nor is there a penalty for longer waiting time. A yes/no response cannot address issues of performance. It would be better to establish a baseline prior to entering into the contract and incorporate benchmarks to reduce waiting time. If, for instance, waiting time was 60 minutes on average for paediatric services, then a benchmark could be set to reduce this time by 50% during the first 6 months and by an additional 25% during the second 6 months of the contract. This would mean a total reduction of 37.5% in waiting time (22.5 minutes) over a 12-month period.

The CCSS conducted a very detailed economic evaluation of the COOPESA LUD contract demonstrating trends and indicators over an 8-year period. However, since the contract itself did not include efficiency indicators, economic evaluation data are not discussed here. This complete and detailed economic evaluation could serve to be the topic of another article in itself.

Conclusions and recommendations

The contract between COOPESA LUD and the CCSS clearly articulates the objectives of the contract. It also contains a very complete list of indicators and an evaluation plan. The CCSS evaluation system itself has many of the components it needs to assess contractor performance; however, there are certain aspects of the system that could be improved upon.

As discussed above, although the CCSS conducts periodic evaluations through formal mechanisms, and some data on volume of service delivery are provided, the data gathered in all three categories examined – organization, service delivery and quality – do not fully provide the purchaser with information related to the contract objectives. The evaluation provides a lot of data on the utilization of services, but it does not provide useful data on improvement in quality of care and efficiency. The indicators contained in the contract are specified and include a series of criteria against which they are to be evaluated; however, the evaluation of contractor performance was not linked to results beyond utilization of services and whether quality of care processes were in place.

One of the problems in setting population-based goals as done under the COOPESA LUD contract for service delivery is that there is no incentive to go beyond meeting the stated goal. If, for example, the indicator for childhood growth and development monitoring is 70% and the contractor goes beyond this goal to cover more than 70% of the target population, then this may be an inefficient use of resources or the target may have been inaccurately set, and the impact may not be worth the effort. Where, however, is the motivation to surpass the goal of 70%? Should a reward be provided for this achievement?

In Costa Rica, the CCSS has a duty to extend health services coverage to 100% of the country’s population; contracting has been one of its strategies for accomplishing this. However, in the case of service delivery indicators, the only way to ensure that the target population is reached would be to expand the geographic area under contract or to redefine the target population based upon real expectations of coverage rates, not the entire population. In other words, rather than pay COOPESA LUD as a function of the entire population of the Pavas district, payment should be a function of the real estimated demand for services, and targets could be set accordingly. This would require an entirely new set of indicators based upon the health priorities of the area and not solely upon population groups.
The indicators for quality of care and their evaluation do not seek to measure quantifiable results or impact. Rather than employ a scoring system of a ‘yes’ or ‘no’ scores, the indicators related to organization and quality could be more specific in order to gather information on performance. As discussed earlier, if the CCSS intends to improve effectiveness and efficiency, although there are no performance indicators to measure these gains, the CCSS Economic Division conducted an independent evaluation of efficiency, but contractor performance was not linked under the contract to standards of efficiency, nor were the contractor’s costs reflected. In order to measure improvements in efficiency, the purchaser must have (1) data on its own production or service costs, and (2) sufficient institutional capacity to determine efficiency indicators and targets and to monitor and evaluate contractor performance towards this goal.

A corollary to the CCSS’s final overall evaluation results, COOPESALUD’s performance was exemplary. Although it did not obtain an overall rating of 100%, and was acceptable under the contract terms.

Endnotes

1 COOPESALUD’s budget is 95% financed by the CCSS, and additional income generated through user fees for non-contract services including dental prosthetics and upper GI tract endoscopy.

2 The following three paragraphs and the criteria for evaluating indicators presented draw heavily upon the work of Knowles and Leighton.

3 Although not defined in the contract, this calculation was made by adding women from the age groups of 15–19 years (3612) and 20–44 years (17 279) to get an aggregate figure of what is customarily known as women of childbearing age 15–45 years (20 891).

4 It is not clear, however, whether the decision to accept compliance with four out of six criteria was made; nowhere does it state that this was acceptable under the contract.

5 The Department of Economic Studies of the CCSS conducted a separate evaluation of financial and production performance of COOPESALUD in 1998 contract. Although the contract itself did not build in indicators to evaluate efficiency, CCSS’s economic evaluation had mixed results. On the one hand, per capita expenditures under the COOPESALUD contract were lower than for CCSS; on the other hand, service expenditures were greater under COOPESALUD than the CCSS clinics.

References


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Biography

Wendy A Abramson is a public health and management expert with over 24 years experience working in international development. She is a specialist in decentralization, planning and management of health systems and institutions; assessment and strengthening of quality management at the institutional level; and contracting. She has worked in the areas of strategic management including health planning, implementation and evaluation; survey design, application and analysis; indicator development, baseline determination, and benchmarking in several countries in the LAC Region. Ms Abramson is currently serving as the Chief of Policy and Planning for Primary Care, Prevention and Planning A administration at the Dis- trict of Columbia Department of Health.

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