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Challenges to effectiveness in public health organizations: The case of the Costa Rican Health Ministry

Carlos Adrian Rodriguez

INCAE Business School, KM. 15.5 Carretera Sur, Managua, Nicaragua

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ABSTRACT

This case provides a setting to analyze organizational problems impeding effective execution in public health organizations in Latin America. This teaching case describes the conditions leading to the weakening leadership of the Costa Rican Health Ministry (CRHM) by the end of September 2014. The document was written based on a combination of interviews with key decision-makers and published/archival data. Students are expected to assume the role of CRHM's General Director, Priscilla Herrera, and propose organizational changes that will improve effectiveness in the ministry's operations. A widespread assumption is that politicians and top-level bureaucrats, due to vested interests or poor judgment, are the root cause of ineffectiveness in the public sector. This case presents a broader picture by suggesting excessive centralization of functions, weak authority lines, conflicting agendas at different organizational levels and regulation rigidities as significant factors affecting public healthcare operations.

"How can we go about regaining effectiveness in the Costa Rican Health Ministry?" wondered Priscilla Herrera, MD, General Director of the Costa Rican Health Ministry (CRHM). During the last week of September 2014, Dr. Herrera spent considerable time analyzing the different reorganization proposals that she had planned to bring to a meeting with her superior, the Health Minister of Costa Rica. These proposals had the objective of addressing the health- related issues raised by the "first 100-day report" (López, 2014), which had been released in the previous weeks and had received major press coverage ever since. The report's results were worrisome, as they pinpointed three major issues in the health ministry: (i) the weakening of CRHM's leadership in the healthcare sector, (ii) its lack of execution capabilities, and (iii) its limited managerial support systems. The president himself called the solution to CRHM's problems a top government priority, as CRHM's lack of leadership was affecting the evolution of human development indicators, or HDI—an area where Costa Rica was losing ground to other nations' progress.

The Costa Rican health system was considered one of the key achievements of the country, providing its residents with a higher life expectancy at birth and lower infant mortality rates than other countries in the region (see Fig. 1). Two pillar institutions of this success were the Costa Rican Security System (CCSS for its Spanish acronym), in charge of providing public healthcare services and, the CRHM, in charge of planning and regulatory activities in the country's health system.

Dr. Herrera had been working with her team designing solutions to address the health issues raised in the first 100-day report. Overall, the team had agreed to focus on improving CRHM's effectiveness, as they believed poor execution (and not the lack of a sound strategy) was the central issue to be addressed. Three main proposals had emerged. The first proposal was to focus on the implementation of an open-source comprehensive Health Information System (HIS) dedicated to the generation of critical health information at the patient, health facility, and population levels in the country. This system would provide CRHM with data to facilitate decision making; at the same time, its integrated capabilities were expected to facilitate the coordination of different health institutions and enhance the surveillance capabilities of the ministry. The second proposal focused on reducing the responsibilities of the General Director and assigning them to other offices at CRHM, with the purpose of allowing Dr. Herrera to increase time spent on strategic and leadership roles in the Costa Rican healthcare sector. The third proposal involved the modification of responsibilities for middle managers, the establishment of performance metrics, and the establishment of performance-driven incentives in key processes, in order to decrease the number of regular situations requiring top management attention. Dr. Herrera wondered about the viability of the different proposals, and in particular, whether she should focus on any of them to regain the sector's leadership while responding more efficiently to the Costa Ricans' health needs.

E-mail address: carlos.rodriguez@incae.edu.

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	Gross Domestic Product (per capita/ In thousand USD)	Lifespan at birth (in years)	General Mortality Rate (per 1,000 people)	Infant mortality rate (per 1,000 live births)
Nicaragua	1,8	74.5	4.58	20
Panama	10,8	77.3	4.91	15
Costa Rica	10,5	79.7	4.21	8
USA	53,0	78.8	8.23	6
Canada	52,0	81.3	7.5	5

Source: Pan American Health Organization, Indicators, 2013.

Fig. 1. Comparison of health indicators, selected countries.

1. The country's environment

Costa Rica was the oldest and most stable democracy in Latin America (Al Camp, 2007). The country had abolished its army since the first half of the twentieth century, which facilitated its peaceful development during periods of turmoil affecting neighboring Central American nations. The country's stability and its low military expenditures facilitated the investment of resources in areas such as health and education, creating significant advances in those sectors. For example, the overall performance of the Costa Rican Health System was ranked by the World Health Organization (WHO) as above that of many higher-income nations such as the United States or South Korea (World Health Organization, 2000).

Despite of its relative success, in the past 20 years, the country's development model had begun to show certain weaknesses. Problems of slow growth, growing inequality, lack of infrastructure, and corruption scandals generated a significant level of discontent among Costa Ricans. Comparisons in terms of HDI showed Costa Rica slipping in the rankings, while other countries (e.g., Uruguay, Panama) were progressing more toward higher positions (Fig. 2 presents the evolution of selected health and social indicators in the period 1990–2013). Popular discontent with the country's situation affected support toward the two traditionally dominant parties in the Costa Rican political arena. This translated into increasing support for the left and the right of the country's political map (see Fig. 3).

In 2014, the Accion Ciudadana's Party (PAC), a center-left political group, won the presidential election in the second round, with a message of anti-corruption and strengthening of the public sector. PAC had a minority in Congress, thus limiting its ability to substantially modify Costa Rican legislation. In this context, and with a small number of tools to generate change, it was important for PAC (and the president himself) to attain improvements in the public sector's operations in order gain power to move forward in its political agenda.

Indicator	1990	2000	2010	2013
Human Development Index (HDI)	0.663	0.705	0.768	0.763
Ranking HDI (Relative position among L.A. Countries)	3	4	6	7
Birth Gross Rate	27.0	20.2	15.6	15.0
Total Fertility Rate	3.2	2.4	1.8	1.8
Lifespan at Birth (in years)	77.0	78.0	79.0	79.7
Years of Schooling in Population between 25 to 64 Years	7.1	7.9	8.7	9.0
Gini Coefficient	0.374	0.412	0.508	0.524
Social Expenditure per Capita in Health (in thousand colones, 2013)	232.0	309.1	337.4	344.2
Support to the Traditional Political Parties (PUSC+PLN) as percentage of total votes	93.9	70.3	38.8	34.5

Source: Programa Estado de la Nacion, El desarrollo humano de Costa Rica en Perspectiva Comparada (1994-2013).

Fig. 2. Costa Rica, evolution of selected social indicators 1990–2013.

The healthcare sector occupied a preeminent position on the new government's agenda for several reasons. On the one hand, successful performance of the sector would serve to improve quality of life for the population, particularly the lower-income strata. On the other hand, the media had taken a very active role in exposing problems that evidenced how the public healthcare sector had deteriorated. It was common to read in national newspapers about long waiting lists in hospitals, a lack of well-trained physicians and supply problems in the infrastructure (e.g., operating rooms, specialized equipment) or key supplies (e.g., drugs or vaccines). A boost in CRHM's effectiveness would raise public support for PAC's administration.

1.1. Relevant actors in the healthcare sector

By 2014, the healthcare sector in Costa Rica was formed by multiple public, private, and international organizations. As previously mentioned, two public actors (CCSS and CRHM) dominated the healthcare sector. CCSS was an autonomous, 50,000-person institution in charge of the provision and administration of the country's public healthcare institutions. CRHM's was a 5000-person ministry whose role was to direct the country's health policy and to ensure its compliance. Beyond public institutions, other relevant participants were:

1.1.1. Private hospitals and clinics

These institutions provided healthcare services to patients not affiliated with CCSS or to affiliated patients who opted for private services. Their participation had grown in tandem with the deterioration of public services with respect to their faltering ability to cope with demand in a timely and high-quality manner.

1.1.2. Labor unions and professional associations

A large share of CRHM's employees were participants in collective associations. These organizations had significant power and had adopted approaches to sustaining their existing labor rights, in particular, with relation to fringe benefits and other incentives. They had opposed reductions to governmental funding and the adoption of more flexible labor contracts.

2. The Costa Rican Health Ministry

CRHM's core mission was to "promote the overall health of human beings" for 4.5 million Costa Ricans. CRHM had broad responsibilities in three specific areas: strategic planning, sanitary regulations and technology development. The scope of CRHM's activities included five central functions: (i) the definition of health policies, (ii) the establishment of health promotion strategies, (iii) the provision of health surveillance, (iv) service quality assessment in health services—public and private, and (v) the enforcement of sanitary regulations.

2.1. Organizational structure

CRHM was organized into three different divisions: general administration, a health oversight division (design of public policies) and regional offices (CRHM's execution arm). Its organizational structure could be described as a hybrid. The general administration and health oversight divisions were functionally organized. The regional offices were geographically organized. CRHM's organizational chart appear in Fig. 4.

Hierarchically, the ministry was organized into three levels: political, strategic, and operational levels. Personnel at the political and strategic levels populated the top of the chart, and they were responsible for designing and issuing strategies and standards. This level was composed of the following offices: the office of the minister, two deputy ministers, the managing director's office, the planning and supervision units, the

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