- To provide ambulatory health care that is easily accessible, of high quality, and integrated with primary health care.
- To involve the community in responsibility for its own health.
- To eliminate bureaucratic constraints.
- To improve the utilization of human, material, and financial resources.
- To promote excellence by means of more selective hiring and better in-service teaching programs.
- To encourage employee motivation and identification with the work of the clinic.
- To foster teamwork.

It is the intent of the cooperative to provide for community oversight of its function. Toward this end, community participation is being cultivated and affiliation with 36 existing community organizations is under way.

Ambulatory care otherwise provided by the Social Security Bureau and certain of those services typically associated with the Ministry of Health are provided by clinic personnel. The latter services, falling under the rubric of primary care, include prenatal care, vaccination, visits to families in their homes on a regular basis as well as when a specific need arises, visits to schools, and community health education. The Ministry of Health retains the responsibility for comprehensive health planning, program evaluation, epidemiological investigation, environmental sanitation, and enforcement of health regulations.

While the experiment in Tibas may resemble the closed panel health maintenance organization familiar to North Americans, it differs in at least two important ways. Contractually bound to serve a defined population, the clinic may not alter its subscriber mix in the interest of ensuring solvency. The incentive to operate efficiently and to promote community health is, therefore, more powerful. Also, the cooperative is not responsible for hospital care. Free of this obligation and its financing, the clinic is able to give priority to the provision of ambulatory and community care.

Outcomes

The cooperative has been able to provide easier access to better care, as judged by clinic clients,[3] and has done so at a cost that is lower to government than the amount that would have been spent under the preexisting arrangement.[4] The bureaucratization that, in the public sector, can result in delays of up to 1 year for procurement or repair of equipment has been eliminated, and a commitment to community participation and organized programming permits greater responsiveness to community needs.

In the year 1990/91, 88% of all visits to the clinic were of a general medical nature, with the balance involving specialty care. Of all cases presented to the clinic, 97.3% were resolved there; 2.7% were referred to more specialized settings. Of all pediatric cases, 90% were attended to in-house. This performance reduces the impact of inappropriate usage on area hospitals. The clinic's emergency service handled an average of 35 patients daily, further alleviating the burden on hospitals in its referral network.

Almost all clinic service is provided on an appointment basis. For those clients presenting without an appointment, the average waiting time is one-half hour. The duration of pharmacy visits is extended by a patient educational component. Physicians see, on average, four patients per hour. Ambulatory surgery affords the advantages of reduced waiting time for the patient and better doctor–patient relationships insofar as the patient is attended by familiar persons.

Data collected in two opinion surveys indicate client satisfaction with the clinic at Tibas. Among 346 patrons, nearly all (96.5%) rate the treatment received as "good" (26.3%) or "very good" (70.2%). Among the advantages of clinic use these clients cited "good care" (59.9%), closeness to home (31.3%), and rapid access (no delay) (26.88%)[3]. In another survey of users of specific clinic services, all but 3.7% of the responses rated the care as "good," "very good," or "excellent."[4]

A cost analysis comparing the clinic at Tibas with four others that are operated by the government but are otherwise equivalent indicates that the public–private partnership offers some advantage. The average cost per consultation at the cooperative clinic in its first 5 months of operation was 44.54% lower,[4] and from July through October 1991, this cost advantage increased. The average cost of a consultation at the cooperative clinic for the 5 month period was 1086 Colones (US $11.25) while that at the four comparison clinics was 1565 Colones (US $16.20).

Conclusions

The cooperative clinic at Tibas aims to provide service of high quality while making rational and efficient use of available resources. There is some question, however, regarding the prospects for extending the model. The prevailing sentiment of many medical professionals in Costa Rica, as elsewhere, is traditional and not geared to this new approach. Until changes in education and training are brought to bear, this attitude may not be altered. Further, while this model may be appropriate for the majority of the population, clustered in the Central Valley, it may require some modification if it is to attend to those of other jurisdictions, including regions of Costa Rica with lower population density and limits on transportation. Nonetheless, the private–public venture in Tibas appears to offer the potential for achieving the integration of Social Security and Ministry functions that has been mandated but not yet accomplished and is an attractive alternative for the provision of health care in settings such as Costa Rica. □

Paul E. Pezza, PhD, MPH, MAT
José F. Barquero Bolanos, MD

Paul E. Pezza is with the Department of Health Policy and Management, Providence College, Providence, RI. José F. Barquero Bolands is with the Clinica Integra de Tibas, San Juan de Tibas, Costa Rica.

Requests for reprints should be sent to Paul E. Pezza, PhD, MPH, MAT, Department of Health Policy and Management, Providence College, Providence, RI 20918.

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Assessing Community Health Concerns and Implementing a Microgrant Program for Self-Help Initiatives

Although the value of giving voice to the community health concerns of marginalized groups is acknowledged, few practical methodologies for doing so are

available. Similarly, despite recognition that even modest resources can stimulate grassroots initiatives, few demonstrations of this leveraging process have been reported. This note describes the involvement of the Work Group on Health Promotion and Community Development at the University of Kansas in designing and implementing two innovations: a process for assessing community health concerns and a microgrants program to encourage self-help initiatives.

In January 1990, portions of the Concerns Report Method[1] were modified to identify strengths and problems in the community related to public health and alternatives for improvement. This process was implemented to identify the health concerns of low-income people in Lawrence, Kan (population 65 608), and surrounding Douglas County (population 81 798). This was the first application of the Concerns Report Method to assess community health concerns.

The Concerns Report Method involves several steps. First, members of a consumer working group—in this case, low-income clients of local health and human service agencies—review a menu of potential issues (e.g., availability of affordable medical and dental treatment). The working group selects, adapts, or creates approximately 30 items to appear on a unique concerns survey. Item categories currently include acquired immunodeficiency syndrome (AIDS) and sexually transmitted diseases, alcohol and substance abuse, adolescent pregnancy, cancer, cardiovascular disease, injury prevention, mother and child health, smoking and tobacco use, basic health issues, and domestic violence. For example, one item related to substance abuse reads: "programs to help people quit smoking are available and affordable." The selected items form a self-administered questionnaire which is set at approximately a fifth-grade reading level.

Second, the questionnaires are distributed through local health and human service agencies. Respondents rate each item on its importance and their satisfaction with it. A formula is used to report percentage importance and percentage satisfaction. Items rated high in both importance and satisfaction are considered relative strengths; those high in importance and low in satisfaction, relative problems. Third, the questionnaire responses are compiled and analyzed and a report of the findings is prepared and distributed to health and human service agencies, city officials, and other interested organizations. Finally, a public meeting is held to discuss identified strengths and problems and generate alternatives.

In this application of the Concerns Report Method, we collaborated with representatives of local human service agencies and organizations. Participants included representatives from the local United Way agency, the county health department, local poverty agencies, an agency serving people with disabilities, the county AIDS task force, an organization working on the prevention and treatment of drug and alcohol abuse, the Council on Aging, the local women's shelter, and the local Visiting Nurses Association. Participants had an interest in specific health issues (e.g., drug and alcohol abuse, adolescent pregnancy, or AIDS), contact with low-income persons, or both. This group—calling itself the Douglas County Coalition on Community Health Concerns—agreed to sponsor a survey to assess the strengths and problems of the county related to community health.

The survey of community health concerns was a volunteer effort. Representatives of the Douglas County Coalition on Community Health Concerns donated their time and resources to photocopy and distribute the survey. Staff at the Work Group collected the surveys, analyzed the data, and prepared and distributed the final report free of charge (the report normally costs approximately 50 cents per completed questionnaire).

The survey was distributed through local health and human service agencies and during distribution days for commodity food programs and the county health department's Women, Infants, and Children Program. Agency representatives and staff from the Work Group invited people to complete the survey. Approximately 300 people completed the survey (the actual response rate is unavailable). The majority of respondents were women with household incomes of less than $10 000 a year. Most respondents were working poor, reporting at least some earnings from jobs.

Major problems identified by the survey included a lack of affordable health insurance (88% importance, 41% satisfaction), medical and dental treatment (90% importance, 42% satisfaction), quality day care (86% importance, 49% satisfaction), and community programs to help pregnant women avoid drugs and alcohol (86% importance, 59% satisfaction). Some relative strengths included the availability of a 911 number for reporting accidents and getting immediate help (92% importance, 77% satisfaction), people's knowledge of the major causes of heart disease (88% importance, 70% satisfaction), and the fact that the schools educate students about the effects of alcohol and drug abuse (90% importance, 66% satisfaction).

Public meetings were held to discuss with Coalition participants and members of the community the issues identified and possible solutions. For example, in response to the lack of affordable health insurance for all people in the community, alternatives identified during the public meetings included purchasing insurance through a broker to get less expensive health insurance, developing a group plan for the medically indigent, and establishing state-funded subsidies for doctors who treat low-income people. In response to the lack of affordable community programs to help pregnant women avoid drugs and alcohol, the alternatives generated included posting signs to advertise available programs and establishing peer counseling programs.

A direct benefit of this application of the Concerns Report Method was the formation of a local health concerns coalition. This group, composed mainly of consumers, was formed to address several identified health issues; its initiatives included a breast cancer awareness campaign and the development of a local detoxification house for alcohol and drug abusers.

The Work Group on Health Promotion and Community Development secured $10 000 from the Kansas Health Foundation (formerly the Wesley Foundation) of Wichita, Kan, to field-test a microgrant program. The program was intended to fund small self-help projects designed to address selected health issues identified through the Concerns Report Method. The funds were awarded to the United Way of Douglas County, which disbursed funds and administered the program. The Work Group solicited proposals, coordinated proposal reviews, and provided technical support for microgrant applicants and grantees throughout all phases of the program.

The microgrants program awarded grants to informal and formal organizations addressing defined community health concerns compatible with the Foundation's primary areas of health promotion and disease prevention: cardiovascular disease, cancer, substance abuse, and maternal/infant care. Priority was given to proposed self-help projects, those with significant involvement by community members experiencing the health problem (e.g., an adolescent pregnancy program led by teenaged

mothers), and projects that encouraged collaboration among community members and organizations.

The community health modification of the Concerns Report Method is a process for setting local agendas for health promotion. As a complement to epidemiologic methods, the method can be used to identify community health concerns of relatively disadvantaged and marginalized groups. The microgrants program provided modest resources to help people affected by health concerns to address them. When used in conjunction with the Concerns Report process, the microgrants program provided a means for leveraging small self-help initiatives consistent with the priorities of marginalized groups. These community health innovations enable consumers to be involved in health planning, contributing to their control over resources that affect their health and well-being. □

Adrienne Paine-Andrews, PhD,
Vincent T. Francisco, MA,
Stephen B. Fawcett, PhD

Requests for reprints should be sent to Adrienne Paine-Andrews, PhD, Work Group on Health Promotion and Community Development, 4086 Dole Human Development Center, University of Kansas, Lawrence, KS 66045.

Copies of the survey and microgrant forms can be obtained from Dr Paine-Andrews for the cost of reproduction and postage. Further information about the microgrants program and about the Concerns Report Method are also available from Dr Paine-Andrews.

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