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Costa Rica Case Study: Primary Health Care Achievements and Challenges within the framework of the Social Health Insurance

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Universal Health Coverage Studies Series (UNICO)
UNICO Studies Series No. 14



Human Development Network

UNICO Studies Series 14
Costa Rica Case Study:
Primary Health Care Achievements and Challenges
within the framework of the Social Health Insurance¹

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The World Bank, Washington DC, January 2013

¹ The case study was developed within the framework of the World Bank's global initiatives on universal health coverage. It was based on the Universal Coverage Challenge Program (UNICO) survey and on a paper that describes the details of Costa Rica's national Health Insurance System. The case study also draws on Policy Issues Papers produced by the Bank and their background documents, and on the preliminary findings of the case study of Costa Rica for the Regional Universal Health Coverage Study carried out by SANIGEST Internacional, a health care consultancy and management company. The case study also benefited from comments of Dra. Rocío Saenz (former Minister of Health of Costa Rica) during the implementation of the UNICO Survey.

The World Bank’s Universal Health Coverage Studies Series (UNICO)

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

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Abbreviations

CCSS	Social Security of Costa Rica, Caja Costarricense de Seguridad Social
EBAIS	Basic Primary Health Care Teams, Equipos Básicos de Atención Integral de Salud
IMAS	Public and Private Institute of Social Assistance, Instituto Mixto de Ayuda Social
PAHO	Pan-American Health Organization
SIPO	Sistema de Identificación de la Población Objetivo
WHO	World Health Organization

Executive Summary

Universal health coverage in Costa Rica is provided through a single national health insurance program. This program, which protects the poor without the pitfalls of a fragmented system, and the sustained policies that have enabled the building of a solid primary health care system, is broadly recognized as a success story (OPS 2004). One reason for its success is that, early in the process, a decision was made to prioritize coverage of a basic package of primary health care services and key public health interventions, with an emphasis on health promotion and prevention for all people, including those outside the formal sector.

Consolidation of universal health insurance coverage took place in the 1990s, when the Ministry of Health stopped providing health services and transferred some inpatient care units and the provision of primary health care services to the social security system. It is primary health care that has contributed in important ways to putting Costa Rica on the list of the top health outcome performers in Latin America and the Caribbean, with life expectancies and infant mortality rates at levels similar of those of European OECD (Organisation for Economic Co-operation and Development) countries.

At the same time new challenges are emerging to sustaining the success of Costa Rica's universal health coverage. Social Security of Costa Rica (Caja Costarricense de Seguridad Social, CCSS) faces increased production costs and demographic and epidemiological changes in a rapidly aging population. A financial accounting review of CCSS Health Insurance conducted by the Pan-American Health Organization and an independent commission confirmed the existence of a rapidly growing gap between revenues and expenditures. Clinical and financial management and information tools are outdated, and there are no tools or data to monitor costs by production units or responsiveness of health care providers. Performance agreements and diagnosis-related groups introduced in the past are yet to be fully exploited as modern management tools. Concern about responsiveness and financial sustainability is growing along with increasing levels of dissatisfaction with long waiting lists, particularly for inpatient and specialized care. The explosive growth of salaries and other compensation benefits over the past five years triggered a broad concern about management of the public health insurance.

Key elements of the pending agenda for policy makers include (a) enhancing CCSS institutional capacity and management at the central and regional levels; (b) developing modern tools to monitor and foster a more equitable and efficient allocation of resources across regional networks; (c) introducing health technology evaluation and adoption of updated clinical guidelines; and (d) establishing priorities of the open list of services to monitor timeliness, quality, and resources, thus making more transparent the de facto rationing of services that generates waiting lists of rationed health benefits. CCSS authorities have acknowledged the urgent need to rein in the growth of expenditures while enhancing efficiency and quality of services. The executive and legislative branches of government and the CCSS board of directors are exploring options to enhance financial sustainability and enhanced organization of health care management that would be more transparent, responsive, and accountable to the population it aims to serve.

1. Objective of the Case Study and Health System Overview

The objective of this paper is to assess the key interventions Costa Rica has developed to expand health coverage for the poor and other vulnerable groups, with an emphasis on its approach to primary health care.

Universal health coverage in Social Security of Costa Rica (Caja Costarricense de Seguridad Social, CCSS) is the culmination of a long process sustained by public policies that expanded social insurance coverage around a model of primary health care and networks of specialized ambulatory and inpatient care. CCSS was established in 1943 and provided health insurance for salaried workers. Later, in 1961, coverage was expanded to workers' dependents. From 1961 to the mid-1970s, a series of laws, regulations, and agreements between the Ministry of Health and the Social Security expanded coverage of primary health care and outpatient and inpatient specialized services to individuals living in rural areas and to lower-income and other vulnerable groups. In 1975, CCSS health insurance coverage was expanded to cover farmers and peasants. In 1978, a voluntary regime for independent workers who could receive partial public subsidies was established. Particularly important in the 1970s was the massive expansion of highly skilled and complementary teams of primary health care providers to serve those not covered by the social health insurance.

It is widely recognized that the adoption of a comprehensive and sustained primary health care strategy, along with expansion of coverage of safe water and sanitation, are the key reasons behind Costa Rica's impressive health outcomes. The country approached universal health coverage through existing social insurance entities, all managed by a single public social insurance institution, CCSS. This approach, combined with investments in education, water, and sanitation (Marín and Ramirez 2004), has been sustained with a strong social consensus through decades and various political parties. Improvements in water and sanitation (still under the Ministry of Health), particularly, explain improvements among the poor in urban and rural areas. In addition, a key aspect was the implementation of a solid and extensive primary health care strategy immediately after the Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC), which contributed importantly to some key health outcomes (OPS 2004; Vega 2008).

Demographic Trends and Health Outcomes

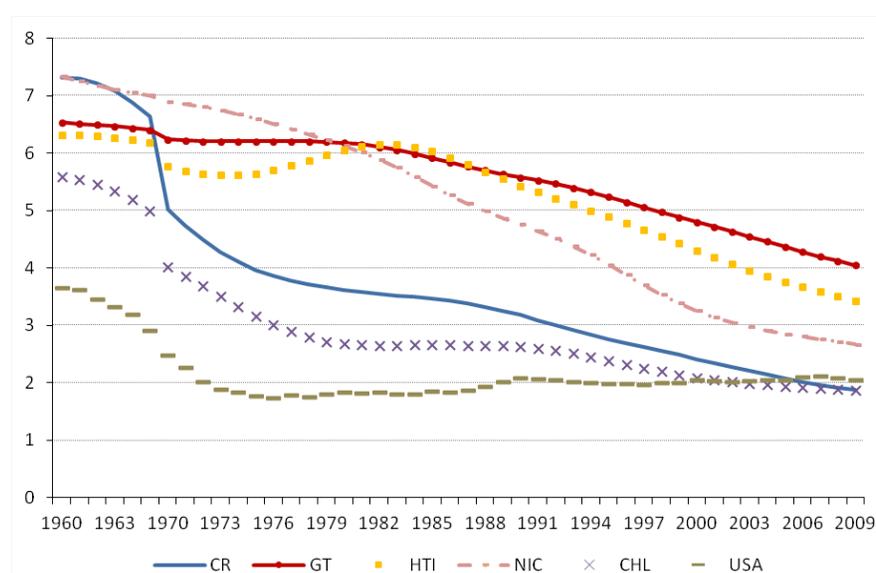
The rapid aging of the Costa Rican population, the global economic and financial crisis, and a rapid increase of medical staff costs have produced gaps in revenues and expenditures in CCSS health insurance that may persist if not tackled in a comprehensive way. Financial imbalances and a lack of publicly available information have raised serious questions about the program's sustainability. There is a decline in young cohorts of the population, even as there are increases in older age groups. The decline in the fertility rate has kept the total fertility rate lower than the replacement rate since 2005 (table 1 and figure 1).

Table 1 Trends in Selected Demographic Indicators, Costa Rica, 1995–2010

Indicator	1995	2000	2005	2010
Total population	3,468,918	3,919,180	4,309,413	4,658,887
Total population ages 0–14 (% of total)	34.36	31.44	27.90	24.90
Total population aged 65 and above (% of total)	5.24	5.48	5.91	6.53
Population growth (average annual growth rate)	2.46	2.26	1.73	1.47
Fertility rate, total (births per woman)	2.80	2.41	1.99	1.83
Age dependency ratio	65.54	58.52	51.08	45.84
Rural population (% of total)	44.20	41.00	38.30	35.70

Sources: CCP 2011; WDI 2012.

Figure 1 Historical Trend in Total Fertility Rate, Selected Countries, by Income



Source: SANIGEST 2012.

These demographic trends are expected to continue for the next 10 to 15 years due to a decline of the child dependency ratio and the rise of the elderly dependency ratio. In the long term, the situation is expected to reverse, with the dependency ratio increasing, given the weight of the growing elderly population. The number of children 0 to 14 years old has decreased from 34 percent of the population in 1995 to 25 percent in 2010 (around 10 percent in 15 years) and is expected to further decrease to 17 percent by 2050. In comparison, in 1990, the population over age 65 represented only 5 percent, but is expected to increase to 21 percent of the total population by 2050. Thus, older groups will make up an ever increasing share of the population.

The causes of this transition are the decline in both fertility (0.9 percent in the last 15 years) and mortality rates and an increase in life expectancy (due to improvements in health and education).

As a result of the demographic transition, the structure of the Costa Rican population pyramid is undergoing dramatic changes. Twenty years ago, the demographic composition had a wide base and a small proportion of people over age 50; that is, the concentration of the population was at the base of the pyramid. However, by 2025, the pyramid will be characterized by widening age groups, especially older groups. Such changes in the shape of the pyramid indicate the transition from a progressive pyramid (wide base and narrow top) to a regressive pyramid (narrow base and wide top and center). Furthermore, overall growth rates have declined from 2.5 percent in 2005 to 1.7 percent, and it is estimated to be 1 percent by 2020. Consequently, families are increasingly composed of older adults as opposed to minors. In addition, over the last 40 years people have been migrating from rural to urban areas.

Table 2 Health Outcome Indicators, Costa Rica, 1995–2009

Indicator	Unit / Ratio	1995	2000	2005	2009
Population	Number (in thousands) total	3,479	3,931	4,328	4,579
	Growth (annual %)	2.47	2.29	1.68	1.32
Total fertility rate	Number of births per female	2.76	2.43	2.10	1.94
Life expectancy at birth (years)	Female	79.2	80.2	80.9	81.5
	Male	74.5	75.5	76.2	76.7
Under-5 mortality rate	Number of deaths per 1,000 population aged under 5	14.4	12.9	11.6	10.6
Maternal mortality rate	Number of maternal deaths per 100,000 live births			36.3	26.7
Tuberculosis incidence	Number of cases per 100,000 population	16	14	12	10
HIV prevalence	Prevalence among adults aged 15–49 (%)		0.10	0.30	0.30
Births delivered by professionals	As a % of total births		98.2^a	98.5^b	99.1^c

Source: World Bank and WHO.

Note: a. Data from 1999. b. Data from 2004. c. Data from 2008.

Between 1980 and 2010, life expectancy increased by more than four years, rising on average to 80 years, which is comparable to various high-income OECD (Organisation for Economic Co-operation and Development) countries. At the same time, the infant mortality rate was halved, and coverage for basic immunization reached nearly 90 percent. The share of mortality attributable to communicable diseases declined from over 65 per 100,000 in 1990 to 4.2 per in

2010, and the share of mortality from chronic diseases increased sharply. Mortality from circulatory diseases increased during the period from 25 per 100,000 to nearly 120.

Noncommunicable chronic diseases now dominate the burden of disease of the Costa Rican population. Cardio-circulatory conditions and cancer are among the most frequent reasons for seeking health services, particularly among adults and the elderly. Heart attacks and cardio-ischemia, and malignant tumors, are among the main causes of death for both genders. Cancer is responsible for 20 percent of all deaths. For women, the second-highest cause of death is breast cancer, while for men it is prostatic cancer. Gastric cancer is the third-highest cause of death for both men and women. In the last 10 years, there has been a 48 percent increase in all types of cancer, and in 2009 alone, an average of three new cases per day were diagnosed in the country. Chronic respiratory conditions, hypertension, and car accidents constitute the majority of the rest of the top 10 causes of death.

National Health Expenditures, Pooling, and Financial Flows

A review of the National Health Accounts reveals that Total National Health Expenditures have grown significantly. The largest increase, however, is not in public expenditures (CCSS or other public entities) but in private expenditures. From 1995 to 2010, the share of private expenditures rose by more from 23.5 percent to 32 percent of Total National Health Expenditures (table 3).

Table 3 National Health Expenditures, Costa Rica, 1995–2010

Indicators	1995	2000	2005	2010
Total health expenditure per capita, US\$ (constant prices)	241.17	272.08	359.78	559.15
Total health expenditure per capita, PPP (constant prices)	168.00	204.00	253.00	553.00
Total health expenditure (% GDP)	6.50	6.50	7.60	10.90
Mean annual real growth rate in total health expenditure ^a	3.03 ^b	7.34	5.29	5.12
Public expenditure on health (% of total expenditure on health)	76.50	76.80	70.30	68.10
Private expenditure on health (% of total expenditure on health)	23.50	23.20	29.70	31.90
Government health expenditure (% of total government expenditure)	20.90	21.70	21.00	29.00
Government health expenditure (% GDP)	4.98	5.01	5.38	7.45
Government health expenditure per capita, US\$ (constant prices)	184.50	209.05	252.82	380.79
Government health expenditure per capita, PPP\$ (constant prices)	293.00	362.00	493.00	845.00
OOP payments (% of private expenditure on health)	87.70	88.20	84.50	87.20
Voluntary health insurance (% of private expenditure on health)	2.60	2.30	9.30	7.70

Source: NHA 2012.

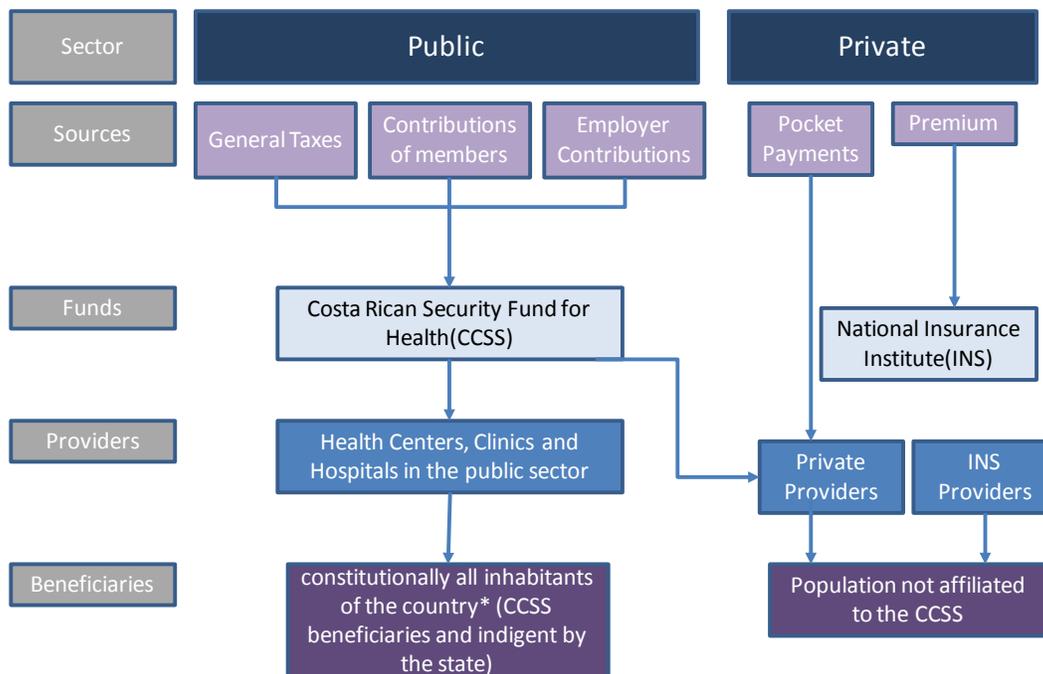
Note: a. Calculated as the mean of the annual growth rates in national currency units at 1995 GDP prices.

b. Data from 2006. PPP = purchasing power parity.

Voluntary health insurance is a small fraction of total private expenditures but nevertheless shows an upward trend. This is not supplemental health insurance coverage but duplicative insurance for benefits already offered. These voluntary health insurances are most likely used to access better facilities, a greater choice of specialists, perceived better-quality medical services, and to jump queues. The negative effect of diminished fiscal revenues on CCSS finances has been compounded in recent years by the contraction of revenues due to the 2009–10 economic crisis. CCSS revenues contracted because employment in the private sector and real wages

decreased, and more people shifted to the informal sector, thereby contributing to lower revenues.

Figure 2 Health System Financial Flows, Costa Rica



Source: Giedion, Villar, and Ávila 2010, 22.

The governance and financing of CCSS health insurance follows the traditional tripartite model of Latin American Social Security institutions. This model includes three key stakeholders: employees, employers, and the government. The board of directors determines premiums and the budget according to actuarial analyses. Fiscal resources provided by the central government provide subsidies for all the regimes—the contributory regime, the partially subsidized voluntary regime, and the noncontributory regime—and its contributions as an employer.

The contributory regime is mandatory for all individuals employed in the formal sector and is financed by a 15 percent payroll tax, which comes from contributions by employers, employees, and the government paying 9.25 percent, 5.5 percent, and 0.25 percent, respectively. The legal and regulatory framework stipulates that premiums paid by the workers shall never be higher than premiums paid by employers. Retired individuals also contribute with a 14 percent rate of pension income. A Voluntary Health Insurance Regime also exists and is financed with contributions from individuals at a 10.25 percent rate of reported income for independent workers (table 4). However, once an individual is enrolled, the contributions become mandatory, since the individual cannot withdraw enrolment from the social health insurance.

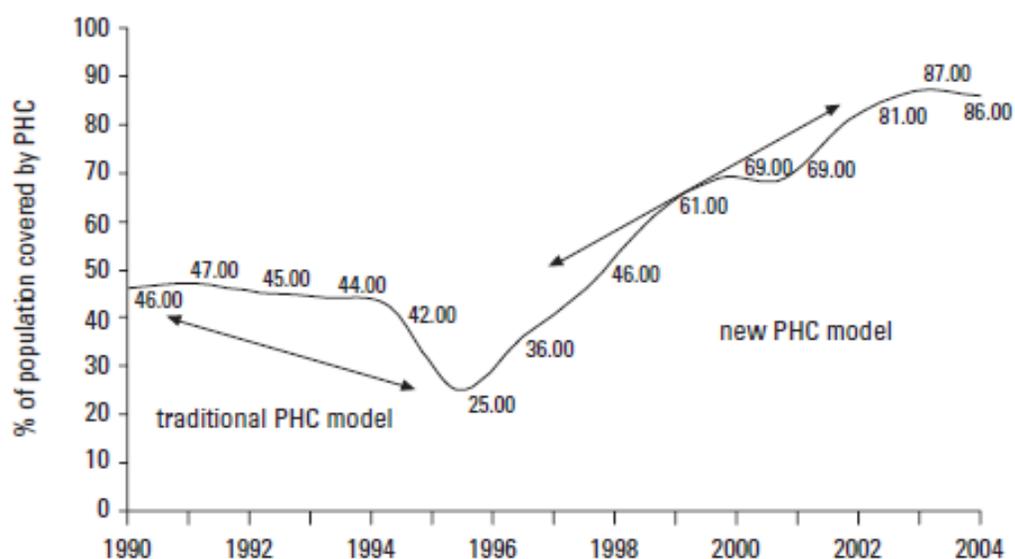
Table 4 Health Insurance Financing Shares by Type of Regime and Source of Revenue

Percent Contribution by Type of Contributor					
Type of Health Insurance	Employee	Employer	State	Pension Regime	Total
Salaried	5.5	9.25	0.25		15.00
Independent	4.75		5.5		10.25
Voluntary	4.65		5.5		10.15
Retiree (Contributory)	5.00		0.25	8.75	14.00
Retiree (Noncontributory)			0.25	13.75	14.00
Insured by State			14.00		14.00

Poor households are covered by the noncontributory regime, with the Ministry of Finance collecting fiscal revenues for this purpose from taxes on luxury goods, liquor, beer, soda, and other imported goods. The estimation of resources needed to finance the noncontributory regime for eligible individuals was based on data from household surveys. CCSS used to estimate the number of poor people, following national standards, and calculated the premium for poor individuals based on the average premium paid by the rest of the contributors at the national level. From 2007 onward, however, the Ministry of Finance started financing the premium only for those poor individuals who are actually registered with CCSS. Other laws and unfunded mandates require CCSS to provide services free of charge to mothers and children, indigenous people, and other vulnerable groups, including the elderly and individuals with disabilities.

All sources of funding are merged into a single pool managed by the central financial administration unit of CCSS. From this large social health insurance pool, resources flow to the administrative and health care units. Resources are allocated to finance inputs through line item budgets. Analysis of public expenditure on health by household income suggests that public expenditure on health has been quite progressive (figure 3). The poorest 20 percent of the population (receiving 4.7 percent of national income), received almost 30 percent of health expenditures. The wealthiest 20 percent of families, who earn 48 percent of national income, received 11.1 percent of social security resources (Cercone and Pacheco 2008).

Figure 3 Trends in Coverage of Primary Health Care, Costa Rica, 1990–2003



Source: Cercone and Jimenez 2008.

Nonexplicit Benefits, Efficiency, Accountability, and the Current Financial Crisis

Costa Rica's social health insurance does not have an explicit benefits package. The main document that regulates the services provided by CCSS health insurance is the "Reglamento del Seguro de Salud" (CCSS 2001). This regulation provides only broadly defined areas of coverage (see box 1) in a fashion similar to the traditional approach to rationing services of other social security institutions in the region. However, implicit rationing takes place, with long waiting lists a prominent feature, as in several other countries with similar approaches to open-ended health insurance benefits. This has posed more challenges to the health system, because demand for ever more complex services is fostered by providers and by the actual needs of an aging population (Cercone and Jimenez 2008).

Box 1 Health Insurance Benefits Provided for in the CCSS Regulations

- a. Health promotion, prevention, and treatment and rehabilitation of ill-health conditions
- b. Specialized and surgical health services
- c. Outpatient and inpatient health care
- d. Medicines
- e. Lab and other diagnostic procedures
- d. Dental care
- g. Social assistance for individual and dependents
- h. Disability cash benefits
- i. Financial support for funeral services.

Although there is no explicit list of exclusions in the regulatory framework, there are in practice a few exclusions based on sound pharmaco-epidemiological analysis for selected medicines. Selected brand medicines that the unit of pharmaco-epidemiology decides can be substituted by generics or alternative therapeutic approaches are not covered. Although occasionally authorities have acknowledged and even agreed to start a process to develop an explicit set of benefits, the actual process has not gone beyond lip service. The rise of legal claims and High Court mandates to provide health care have recently spurred a new wave of interest in the benefits package. Political commitment to this objective by the government and other key stakeholders remains to be seen. The minister of health is fostering development of a health technology assessment group in collaboration with the scientific community, but this is still in the exploratory stage.

Key stakeholders have been unsuccessful in enhancing accountability in the allocation and use of resources linked to intermediary health outcomes. Discussions on the split of purchasing and provider functions as defined by the World Health Organization (WHO) historically have been difficult. This has been a particularly delicate area of policy discussion within CCSS and among decision makers in the executive and legislative branches due to the concerns of physician organizations and other medical associations. The lack of readily available information impedes analysis on equity of allocation of resources among different regions and across the most basic health care catchment areas. The challenge of achieving consensus with physicians' associations and medical staff trade unions on salary, benefits, and other financial resource allocation policies has impeded changes to the existing highly centralized management system. Historical and global budgeting practices allocate resources with mechanisms that provide little incentive to improve the performance of CCSS individual health facilities and the regional networks to which they belong.

In the past, some tools were introduced with the objective of fostering new incentives to boost productivity within the framework of an efficient allocation of resources for hospitals (that is, performance agreements, diagnosis-related groups). However, these tools have not been fully used to create incentives for more efficient purchasing. Performance agreements have been institutionalized. However, the number of indicators and the lack of adequate information systems make benchmarking less effective. Medical and other key hospital staff have become quite familiar with the software that CCSS has used in inpatient facilities in the last 10 years. Diagnosis-related groups are used to measure hospital productivity as part of the performance agreements; however, there has been no work on the financial aspects of this tool and no development of weights for using diagnosis-related groups to allocate resources to hospitals fostering incentives for efficiency.

In March 2011, as part of an agreement between the central government and CCSS to get an independent review of the financial situation of the public health insurance, the CCSS board of directors finally decided to ask the Pan-American Health Organization (PAHO) to assess the situation (Montenegro Torres 2012). The unprecedented scrutiny of CCSS finances shed light on the most acute financial issues. A team of five experts and specially designated CCSS staff analyzed a wealth of budgetary, financial, and accounting data. The final report focuses exclusively on financial and accounting indicators, budget execution, and financial flows.

Although no formal recommendations were made, the report presents three scenarios with financial projections based on changes in revenues and expenditures. The overall conclusion was

that to solve the crisis in the short term, CCSS must implement measures to increase revenues and contain costs (OPS 2011). CCSS convened a committee of independent national experts to analyze and make short- and medium-term recommendations on improving the sustainability of the social health insurance. In July 2011, the CCSS board of directors set up an independent multidisciplinary commission of national experts to review the financial assumptions and projections of PAHO's report and to produce a set of recommendations for the short, medium, and long term. The final report, completed in September 2011, includes 81 recommendations organized in three sections: revenues, expenditures, and institutional management (Carrillo et al. 2011).

CCSS introduced several cost-containment measures aimed at reining in costs for the short and medium term, most of which are in line with the recommendations of the independent commission. CCSS freezes on benefit increases and on hiring new physicians, and the replacement of expensive part-time contracts with full-time contracts, are feasible and appropriate but have unleashed unrest, and medical staff associations and trade unions have called for national strikes. Furthermore, it is not clear whether these measures will be sufficient to reestablish financial stability in the short term and enhance the sustainability of CCSS for the mid- and long term.

The board of directors and other high-level officials are expected to closely monitor the short- and medium-term results and ensure that measures are timely and effectively implemented. The Minister of Finance, along with the Minister of Health and other high-level officials, are exploring options for a policy dialogue on the future of the universal health insurance model and its sustainability. Both the Ministry of Health and CCSS have expressed interest in engaging international agencies to deliver technical inputs to better understand the available options, including reviewing current trends in universal health coverage financing, the experience of other countries with similar problems, and best practices around the globe.

Health Insurance Coverage for the Poor and other Vulnerable Groups

The target groups of the noncontributory regime include the poor, indigenous populations, and the elderly and other individuals who need income assistance (that is, individuals with disabilities). There are no special provisions per se that are intrinsically part of the noncontributory regime. However, the elderly who are poor and other individuals have additional non-health-care benefits as part of the safety net. There are some general guidelines and principles to reduce access barriers for indigenous peoples and other vulnerable groups. There is a partially subsidized regime for independent workers and other nonpoor individuals and those from the near-poor, which in principle is voluntary, with contributions determined by the individual's income. Although voluntary, once enrolled, individuals cannot stop making the established contributions. There is an efficient system for tracking individuals enrolled in the contributory and partially subsidized regimes.

The CCSS has various mechanisms to reach the poor and other vulnerable populations. The strongest tool is the primary health care units (EBAIS). This approach to provide health promotion, prevention, and first level of care provides the most powerful mechanisms to reach the poor. The EBAIS conduct visits to each household in their catchment areas and collect a large amount of information on the family. However, internal regulations require that enrolment

be done in designated facilities and in person by the individual or her or his head of household. Information is collected by EBAIS and other information is collected, and only after it is checked against other national databases is the individual enrolled. The process also informs the beneficiary of his or her rights and duties. This cumbersome process makes difficult the enrolment of the poor and other vulnerable populations, which in part accounts for about 10 percent of eligible individuals not yet enrolled.

There is a system of identification of the poor for the provision of social assistance services (Sistema de Identificación de la Población Objetivo, SIPO), but it is not used for identification of beneficiaries or enrolment of subsidized health insurance. A public sector institute (Instituto Mixto de Ayuda Social, IMAS) developed and manages the mechanisms for identification of the poor. It is not designed to identify all the poor, but rather those households eligible for specific services such as grants for education, social assistance provided by national charity organizations, and so forth. CCSS does not use SIPO for identifying the eligibility of the population; rather, it uses its own criteria and mechanisms to identify socioeconomic status and eligibility.

The capacity of CCSS is, however, extremely limited due to a lack of adequate platforms and information systems. No person is denied emergency services, and frequently the poor are identified when they use specific services (specialized ambulatory or inpatient) delivered in facilities near to one of the units in charge of the identification process. When an individual seeks services in a health center, the EBAIS can identify individuals according to socioeconomic status through a household survey with 267 variables including health and risk factors that the EBAIS team administers. The health center will confirm the information and visit and interview the household before formally enrolling the individual. The identification of the individual is based on the national identity card number and a CCSS beneficiary card which contains this and other information relevant for administrative purposes (that is, type of beneficiary, employer, work address, and so forth). Individuals enrolled do not need to be recertified and remain as beneficiaries of the noncontributory regime unless their work status changes and they enroll in the contributory regime.

2. Primary Health Care and the Organization of Health Services within CCSS

Primary Health Care and the Organization of Delivery of Health Care

Costa Rica's primary health care model was developed more than 30 years ago and was soon adapted to meet the goals of Alma Ata's call for "health for all." The health care model adopted by CCSS is based on the Primary Health Care Model advocated by WHO and more recently conceptually elaborated by PAHO. The model places an important emphasis on community and family health.

The excellent health outcomes in Costa Rica have been achieved with the support of an efficient organization of primary health care services through integrated regional networks. CCSS organized the delivery of health care in three health networks (Northwest, East, and South). The catchment area of each network is subdivided into units with smaller catchment areas (known as health areas). In turn, each health area is subdivided into even smaller units at the center of which is the health center, with its corresponding family health and community outreach teams.

The Ministry of Health led the improvement and expansion across the country of primary health care units to contribute to the attainment of universal coverage. In addition, during the 1970s and 1980s, Costa Rica's Ministry of Health placed an important emphasis not just on first level of care ambulatory services but, more importantly, on community and family health and on safe water and sanitation in rural and remote areas. By the early 1990s, the model of primary health care services had been developed and implemented, particularly serving individuals outside the formal sector, lower-income groups, and households living in rural areas.

As part of a wave of reforms aimed at separating the stewardship function from the purchasing/provision, the primary and other health care units were transferred from the Ministry of Health and merged with health care services provided by CCSS to contributory and subsidized regimes (sometimes referred to as the new Primary Health Care). The vision was to move progressively to an integration of first, second, and third level of care to improve the continuum of care. The transition was not entirely smooth, and CCSS and the Ministry of Health faced challenges expanding universal coverage to the uninsured. Reference and counter-reference between health centers (EBAIS) and the network of hospitals providing ambulatory and inpatient care remains a weak point in the continuum of patient care.

Currently, the primary, secondary, and tertiary levels of service are managed by CCSS in a highly centralized system, as is the vertically integrated network of financial and administrative organization of services. Services are organized as a pyramid, with basic health center units covering the entire territory at the bottom, secondary level of care units in the middle, and, at the top, third level of care hospitals delivering specialized ambulatory and inpatient services, along with five care units for other specialized services (that is, high-complexity pediatric services, psychiatric hospitals). However, coordination of care needs to be strengthened, both between first and higher levels of care and between second and third levels of care hospitals. A slow rate of investment in modernizing and upgrading an aging hospital infrastructure impedes the efficient triage of patients to the second or third level.

The country is divided into 104 health areas, each covering about 50,000 individuals. Basic Primary Health Care Teams (Equipos Básicos de Atención Integral en Salud, EBAIS) are assigned to health centers in each of the health areas and assume the responsibility of providing promotion, preventive, and curative services. The standard EBAIS health team consists of a physician, a nurse, and a technician. These teams serve as reference and counter-reference points for individuals to use other services available at different levels of care within the corresponding network.

Each network provides health services at each of the three levels of care.

- The **first level of care** responds to approximately 80 percent of the population's health needs, with the other 20 percent of more complex interventions being addressed by the specialized ambulatory and inpatient services in higher levels of care. For individuals and families, the first level of care provides health promotion and prevention services and acts as gatekeeper to the health system.
- The **second level of care** provides specialized consultations, hospitalization, and medical and surgical treatment for certain basic specialties. These services are provided by nine health centers and 13 peripheral and 7 regional hospitals.

- The **third level of care** provides specialized services and complex medical and surgical treatment through 3 general and 6 specialized national hospitals (for women, children, geriatric care, psychiatry, rehabilitation, and ambulatory care).

Costa Rica had almost two physicians per 1,000 persons (PAHO 2012), which compares very favorably with the Latin America average, and which is higher than in many countries. Costa Rica also has far more hospital beds per 1,000 persons than other middle-income countries and a higher ratio than some upper-middle-income countries such as Panama and Chile.

Health staffing has increased significantly in recent years, with a spike in the last five. Between 1995 and 2010, the total number of physicians and dentists (per 1,000 habitants) increased around 50 percent and the number of nurses doubled (table 5). These resources are higher than other countries in the region; for example, Chile had 1.08 nurses per 1,000 inhabitants in 2010, and Panama had only 0.52 nurses per 10,000 inhabitants in 2008.

Table 5 Physical and Human Resources and Utilization, Costa Rica, Selected Indicators and Years

Indicators	1995	2000	2005	2010
Hospital Beds (per 1,000 population)	1.70	1.50	1.40	1.20
Occupancy rates	80.28	81.67	83.14	84.17
Average length of stay	5.84	5.46	5.33	5.49
Physicians (per 1,000 population)	1.27	1.15	2.00	1.86 ^b
Nurses (per 1,000 population)	0.95 ^a	0.89	1.53	1.91 ^b
Dentist (per 1,000 population)	0.38 ^a	0.39	0.65	0.87 ^b

Sources:CCSS 2012; ECLAC 2012; PAHO 2012.

Note: a. Data from1996. b. Data from 2009.

The EBAIS collect a rich array of socioeconomic, demographic, and epidemiologic data on risk factors critical for the implementation of high-quality primary health care. EBAIS are the key instruments of Costa Rica’s approach to primary health care that also contribute one of the more interesting health information features that Costa Rica has—the Household and Family Health Record (Ficha Medica Familiar). This is a virtual census conducted annually by primary health care teams gathering data with detailed interviews of each household in the country. Since they are familiar to the population, they have the trust of individuals, who share key information. EBAIS teams use these surveys for planning, implementing, and evaluating the results of public health interventions in their geographic catchment areas. Although the data collection tool that was introduced in the early 1970s has evolved in comprehensiveness and sophistication, it has not yet been fully digitalized or linked to other sources of data. The survey has more than 260 indicators collected annually, which is considered a virtual census that can be exploited for different social policy purposes beyond the health sector.

Despite the existence of large administrative and health care databases, analytical capabilities for national and regional level decision makers are limited, since data are not yet fully digitalized. Furthermore, the current financial and key areas of the CCSS human resources management system use outdated digital technologies. Information management has evolved into silos of data that cannot provide basic elements of individual costs or equity in the allocation of resources.

Antiquated and fragmented information systems also hinder potential cost-containment analysis and identification of measures to ensure quality of care and quality of spending.

Table 6 Share of Public Spending on Health among Countries with Similar GNP per Capita but Very Disparate Child Survival (to Age 5) Rates, 1995

Ratio*: percent of expenditures for health from the government to poorest 20% vs. richest 20% of population				
	High child survival	Low child survival		Additional children lost per 1000
Sri Lanka	1.1	Ivory Coast	0.3	150
Malaysia	2.6	Brazil	0.4	45
Costa Rica	2.1	South Africa	0.9	55
Jamaica	3.3	Ecuador	0.2	25
Nicaragua	1.0	India	0.3	50
Egypt	0.6	Ivory Coast	0.3	100

*Ratios of one or more signify a greater share of government expenditures to poorest segment of population.

Sources: Calculated from Karolinska Institute, Global health chart, www.whc.ki.se/index.php. Victora et al, Lancet 2003; 362:233-241. Castro-Leal et al, Bull World Health Organ 2000; 78:66-74. Carr. Improving the Health of the World's Poorest People. Population Health Bureau, 2004.

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Robust financing and organization of primary health care is credited with being instrumental in enhancing equity in the health sector in Costa Rica (table 6). International comparisons of health outcomes suggest that Costa Rica's health sector and public health financing has yield more equitable outcomes. However, there is little analysis that focuses on the progressivity of key interventions of Costa Rica's Primary Health Care System. To address this issue, and using tools developed by the Bank ADEpT,² a detailed analysis of equity in Costa Rica's health system (access to health services and financial protection) is underway as part of a World Bank regional study on Universal Health Coverage in Latin America and the Caribbean.

3. Agenda of Key Policy Decisions for a Renewed Primary Health Care Approach as Part of a more Responsive and Sustainable Health Insurance System

Four Key Policy Decision Areas for Policy Makers

First, Costa Rican policy makers urgently need to improve their capacity to understand what the key elements are that hinder efficiency and equity of resource allocation for institutions in general and for health insurance in particular. Also urgently needed is an in-depth analysis to understand what the cost structure is of all the services provided, what has been achieved, and what the challenges are to achieving enhanced efficiency and quality of care. Certain key investments in basic technology are also needed that would allow authorities to better monitor key cost and performance elements at the national and regional level. Clearly, in the medium and long term, CCSS cannot avoid important tools of basic modern technology that any institution of even lower-income countries can afford. However, the government has to establish a list of

² AdePT is the World Bank's Software Platform for Automated Economic Analysis.

investment priorities that can in the short term yield tools for improving both financial administrative and clinical management.

Second, improvement is needed in the integration of health care network management to ensure the continuum of care throughout all levels of care. Decentralization of health care units has not resulted in enhancements of a coherent strategy for improving the health of the population. In some cases it has resulted in the increased costs of individual sophisticated treatments that do not always benefit those in greatest need. Furthermore, some tertiary level hospitals provide duplicate acute care, thus reducing the potential benefits of specialization and economies of scale.

Strengthening of the three health care networks is a pending issue, particularly regarding improved use of tertiary level hospitals. Better management of secondary hospitals, and better facilities, are needed to improve access to specialized services and to minimize patient referrals to third level hospitals, which crowd out costly beds and services needed for highly specialized treatments. Since all budgets and decisions are made centrally, there is no management of networks. It is important to consolidate regional networks, establishing specific units in charge of managing an integrated network of providers at all levels of care in each of the three regional networks. These network management units can avoid the pitfalls of decentralized units (particularly hospitals) working with little or no coordination with other health care facilities. Working in silos runs contrary to an efficient approach to equitable health care interventions, which can be better achieved through integrated networks that focus on health promotion, prevention, and patients' support to navigate the network of outpatient, inpatient, and specialized care services.

Third, policy makers need to enhance accountability of public health institutions by ensuring that patients know their rights and that there are clearly established standards of timeliness and quality of services, with an emphasis on those that are the result of evidence-based medicine. Public opinion emphasizes the overall lack of accountability to the extent that policy makers cannot avoid addressing this issue, not only from the public finance and fiscal perspective, but also from the perspective of quality of services. Authorities need to decide on the development of mechanisms that can provide more transparent information on how finances are managed but also how health care and benefits are decided. Health authorities are considering how to expand the use of evidence-based medicine through health technology analysis, clinical guidelines, and health care pathways.

Finally, it is paramount to ensure a streamlined process that can enhance synergies with other social sector policies regarding targeting and enrolment of the poor. Key stakeholders involved in social assistance and safety net services, including the Ministry of Finance and the Social Security, need to agree on how to identify and target the subsidies for the noncontributory regime. Identification mechanisms should be harmonized across all institutions that target the poor, and ideally the poor should be enrolled mainly by the EB AIS or at the first level of care.

Annex 1 Summary of Recommendations of the Independent National Experts Commission

An Independent National Experts Commission was established by public authorities to review the results of the financial and accounting evaluation developed by the Pan-American Health Organization, and to develop their own recommendations on financial sustainability and improving the responsiveness of the health insurance system. The commission included a list of both specific and general recommendations, which are summarized below.

Revenues

- Implement a review actuarial model and develop conservative estimates of employer and employee revenues.
- Reach an agreement with the Ministry of Finance on the total amount of the accumulated debt and a schedule of payments.
- Develop a proposal for a law to be discussed by the National Assembly on the fiscal contributions outside the obligations of the central government as an employer. The total contribution should be 0.45 percent of GDP and regulations should be formulated to enforce full and timely payment of these revenues.
- Formulate various adjustments and new regulations on contributions and corresponding base salaries of formal and nonpoor informal workers and foreign nationals living in Costa Rica, and on inventory and streamlining of contributions, with special agreements for workers in the informal sector.
- Conduct an external evaluation of the database of the beneficiaries of health insurance fully subsidized and financed with fiscal resources.
- Improve monitoring and enforcement of contributions at the central and local levels.

Expenditures

- Set a cap of 60 percent of total health insurance expenditures for salaries and benefits of CCSS employees.
- Eliminate overtime and payments to medical staff in health establishments located near hospitals.
- Redesign the system of allocating the hours of medical staff on duty and on call, to ensure efficient allocation of human resources. Also, tighten controls of medical staff compliance with contractual agreements regarding complete and continuous working hours, and monitor staff productivity.
- In 2012, the levels of expenditure on overtime payments for medical staff must be similar to that of the 2008 budget, and sanctions should be established if these budgetary limits are not complied with by the health units.
- Reduce the total number of positions (by an estimated 25 percent) at the central administrative level either by reallocating resources to provision of health services or elimination of existing positions. Set growth of staff at the central level not higher than 1 percent annually.
- Develop interventions for negotiating with staff associations and trade unions to set caps on and to lower salary increases, and postpone implementation of increases already agreed with medical staff to take place in 2012.
- Suspend salary compensation for annual leave (vacation).

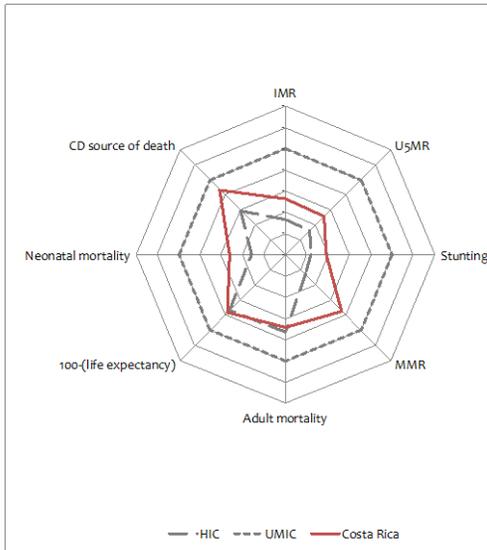
- Various interventions should be developed to limit expenditures on retirement and payments for related benefits.
- Recentralize procurement of all medicines and medical devices used by hospitals and other units.
- Explore options for improving contracting and purchasing of medicines including digital tools and framework agreements.
- Set annual caps on direct contracting and purchases for emergencies.
- Improve availability of public information in real time on the medicine tracking system and improve internal audits.
- Conduct a cost-effectiveness study on the universal coverage of the pneumococcus vaccine and, according to results, review guidelines for the vaccine.
- Reduce fraud and abuse of health permits.
- Migrate to the use of free software used across the CCSS in two years.
- Freeze grants for studies abroad in 2011 and 2012 and set caps for the future.
- Comply with the institutional policy of contracting out services only in those situations of exception where services cannot be provided by the CCSS.

Budgeting

- Publish on the Internet the budget, modifications, the executed budget, and the documents and notes on ordinary and extraordinary budget approvals provided by the office of the General Comptroller (Contraloría General).
- Draft a law to bring back the budget of the CCSS under the Budget Authority on issues related to the general budget, staffing, salaries, and investments.
- Strengthening management to enhance quality of services.
- Replace top managers within 18 months.
- Restructure, reduce, and streamline central level management structures.
- Strengthening the functions of planning, monitoring, and evaluation across management units (“gerencias”) by establishing a specialized unit.
- Commissions should be created with directly responsible managers and clear deadlines.
- Guarantee investments in infrastructure of at least 6 percent of the total annual budget of the CCSS health insurance.
- Take various actions to improve transparency and accountability of different levels of management.
- Reverse the process of decentralization (desconcentración).
- Strengthen the health care networks along with changes in resource allocation.
- Declare electronic medical tools an institutional priority with clear deadlines for their implementation in the three levels of care.
- Within a year, develop an accurate system of cost estimation for provision of services.
- Deal with conflicting interests of physicians practicing in public and private facilities at the same time.
- Establish positions of Hospital Managers to be filled by specialized professionals and not physicians.
- Develop a system of transparent information on waiting lists in six months.
- Strengthen preventive public health interventions.

Annex 2 Spider Web

I. Outcomes comparisons: Costa Rica and Upper Middle Income Countries

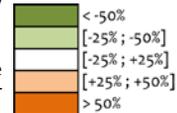


Note on interpretation:

In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

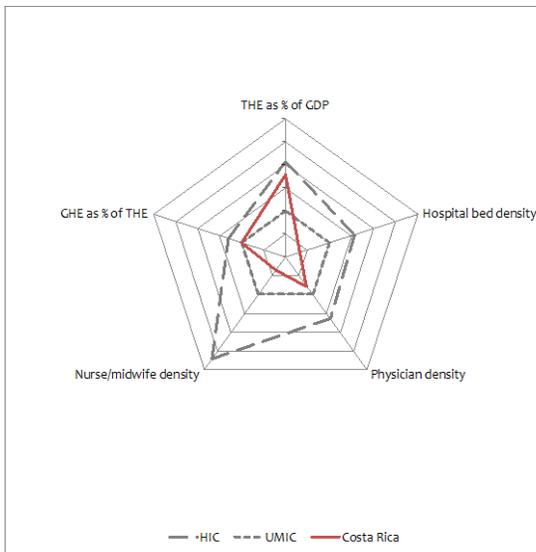
The table below summarizes outcome comparisons with the average upper middle income country (UMIC).



Country Data	Costa Rica	UMIC	% Diff.
GNI pc (2000 USD)	3749.9	1899.0	97.5%
IMR	8.7	16.5	-47.3%
U5MR	10.1	19.6	-48.6%
Stunting	5.6	14.8	-62.0%
MMR	40.0	53.2	-24.9%
Adult Mortality	109.8	160.6	-31.6%
100-Life Expectancy	20.8	27.2	-23.4%
Neonatal Mortality	6.0	11.4	-47.4%
CD mortality	19.0	22.0	-13.6%

IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

II. Inputs comparisons Costa Rica and Upper Middle Income Countries

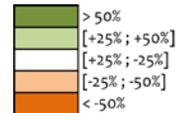


Note on interpretation:

This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

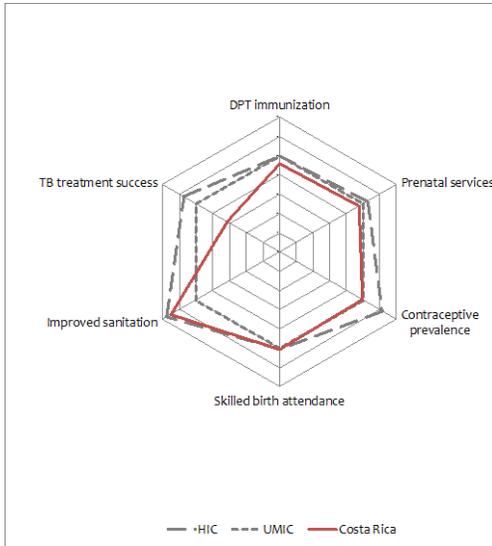
The table below summarizes inputs comparisons with the average upper middle income country (UMIC).



Country Data	Costa Rica	UMIC	% Diff.
GNI pc (2000 USD)	3749.9	1899.0	97.5%
THE %GDP	10.9	6.1	79.0%
Hosp. bed density	1.2	3.7	-67.3%
Phys. density	1.3	1.7	-21.9%
Nur./midwife dens.	0.9	2.6	-64.3%
GHE %THE	53.7	54.3	-1.1%

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

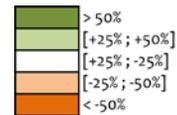
III. Coverage comparisons Costa Rica and Upper Middle Income Countries



Note on interpretation:
In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average upper income country value.

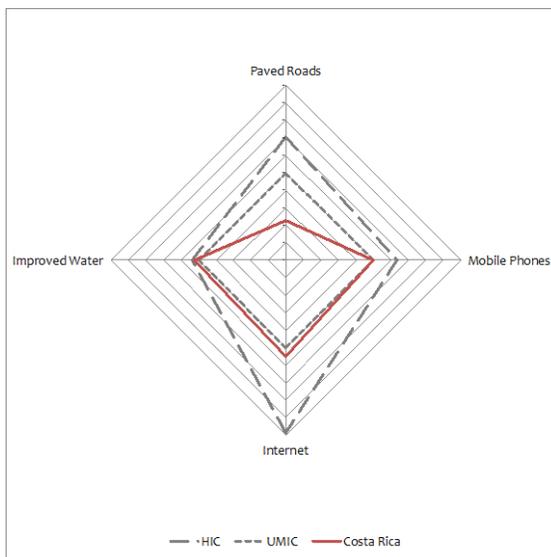
The table below summarizes coverage comparisons with the average upper middle income country (UMIC).



Country Data	Costa Rica	UMIC	% Diff.
GNI pc (2000 USD)	3749.9	1899.0	97.5%
DPT	88.0	95.8	-8.1%
Prenatal	89.9	93.8	-4.1%
Contraceptive	80.0	80.5	-0.7%
Skilled birth	99.3	98.0	1.3%
Sanitation	95.0	73.0	30.1%
TB success	54.0	86.0	-37.2%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

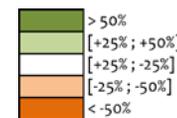
IV. Infrastructure comparisons Costa Rica and Upper Middle Income Countries



Note on interpretation:
In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

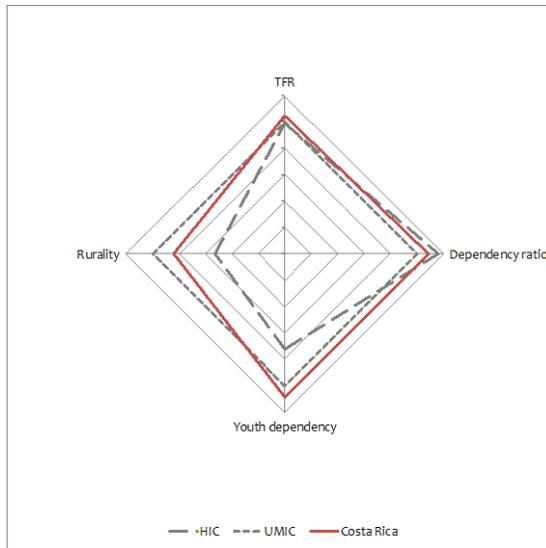
The table below summarizes infrastructure comparisons with the average upper middle income country (UMIC).



Country Data	Costa Rica	UMIC	% Diff.
GNI pc (2000 USD)	3749.9	1899.0	97.5%
Paved roads	26.0	57.6	-54.9%
Mobile phones	92.2	92.3	-0.1%
Internet	42.1	38.3	9.9%
Water	97.0	92.6	4.8%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

V. Demography comparisons Costa Rica and Upper Middle Income Countries

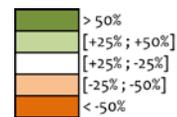


Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

The table below summarizes demographic indicators comparisons with the average upper middle income country (UMIC).



Country Data	Costa Rica	UMIC	% Diff.
GNI pc (2000 USD)	3749.9	1899.0	97.5%
TFR	1.9	1.8	4.5%
Dependency (Total)	45.8	42.2	8.4%
Youth share	79.3	73.0	8.6%
Rural pop.	35.7	42.6	-16.1%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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