COUNTRY CASE STUDY

UNIVERSAL HEALTH INSURANCE

IN COSTA RICA

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1. OVERVIEW OF POLITICAL, SOCIO-ECONOMIC AND HEALTH CONTEXT

Although Costa Rica is now classified as an upper middle-income country, it was a relatively poor country during the period of Spanish colonial rule. On independence, the planting of coffee on a large scale was initiated, with most of the crop being exported to Europe. At the end of the 19th century, the USA leased thousands of acres of land to plant bananas. Until this point, small-scale peasant farming had been the major activity, although a small group worked on coffee plantations. With the advent of the banana plantations, there was a clear shift from peasant farming to the formation of a working class. At this time, there were deteriorating living conditions and increased working class activism. Agriculture remains a key economic activity and coffee the main export in Costa Rica. However, electronics, software development and pharmaceutical manufacturing are rapidly expanding industries. Ecotourism is also becoming a key economic activity.

Macro- & socio-economic and demographic indicators	
GDP (USD 2005 Billions)	19.4
GNI per capita (USD 2005)	4,590
Gini coefficient (2000)	46.5
Urbanisation (% total population)	62%
Literacy (% population aged 15+)	95%
Population (Millions 2005)	4.3
Unemployment rate (2005)	6.7%

Labour force structure by sector (% of labour force) (1999)	
Services sector	58%
Agriculture	20%
Industry and manufacturing	22%

Health sector financing/expenditure indicators (2003)	
Health expenditure, total (as a percentage of GDP)	7
Health expenditure, public (as a percentage of GDP)	6
Health expenditure, public (% of total health expenditure)	79
Health expenditure per capita ($)	305

Health status indicators	
Infant mortality rate (per 1000 live births)(2004)	11.3
Under 5 mortality rate (per 1000 live births)(2004)	12.6
Maternal mortality (per 100, 000 live births)(2004)	33
Life expectancy at birth (years)(2004)	78.7

Sources: WHO National Health Accounts website for health care financing statistics; World Bank website for all other data

In the 1940s, a populist government came to power and introduced the first social security and workers rights legislation. Since the end of World War 2, Liberación Nacional has been the dominant political group, which supports a social democratic approach. Costa Rica is widely regarded as a model of political stability in the Central American region. There is a long history of diverse and aggressive public welfare programs, with particular emphasis placed on the health sector. Health care and social security are considered to be, along with free primary school education, the pillars of the Costa Rican democratic system. As a result of these policies, Costa Rica has a very high level of literacy and has long been regarded as a success story in terms of achieving excellent health status despite having relatively low levels of economic resources. Non-communicable diseases (especially diseases of the circulatory system and cancers) and injuries are the major causes of death. Communicable diseases account for less than 7% of deaths, with the major causes being acute respiratory infection, diarrhoea and AIDS.

2. DEVELOPMENT OF THE HEALTH SYSTEM

In the early 1900s, most health care in Costa Rica was provided by private doctors and charitable organisations. The President elected in 1940 was a doctor who had studied in Europe and was familiar with European social security systems. In late 1941, the Caja Costarricense de Seguro Social (CCSS) – a social health insurance scheme - was established. Coverage was limited to sickness and maternity care for workers living in national and provincial capitals who earned less than 400 colones a month (i.e. the lowest income workers). By 1950, the CCSS covered 8% of the population. Coverage was then extended to rural workers and the salary limit raised to 1,000 colones and by 1961, 18% of the population was covered.

In 1961, the Universal Coverage Amendment Act was passed which envisaged extending CCSS coverage to the entire population within 10 years. The first step towards universal coverage was to remove the salary limit for contributors, so that *all* salaried workers were required to make monthly contributions to the CCSS and workers' dependents were also covered. The distribution of these mandatory payroll contributions was such that employers paid the equivalent of 6.75% of salaries as a

CCSS contribution, workers paid 4% and government a further 0.25%. Initially, the self-employed could join on a voluntary basis for a small contribution, while government was fully responsible for contributions for the poor, handicapped and elderly. National lottery revenue and revenue from 'sin taxes' (particularly taxes on cigarette products) were also directed to the CCSS. In 1970, more than 95% of the CCSS budget was derived from payroll taxes (mandatory insurance contributions) but this was reduced to less than 50% in 1978. CCSS revenues increased 10-fold between 1970 and 1980. By the late 1970s, health care spending had risen to 6% of Gross National Product, 63% of which was attributable to the CCSS and the rest to the Ministry of Health. In relation to population coverage, only 45% of the population was covered by 1971 (the target date for universal coverage), but this was increased to 75% coverage by 1981 and to 85% by 1990. Thus, coverage was extended in the 1970s by bringing in the self-employed and particularly those who could not contribute themselves (poor, handicapped and elderly) with substantial tax funding being devoted to achieving this coverage.

From an early stage, the CCSS built its own hospital and outpatient facilities and began employing salaried doctors and other health workers. In areas without CCSS facilities, services were purchased from charitable hospitals. The CCSS did not purchase services from private for-profit providers, which were regarded as providing low quality health services. To advance universalisation, all charity hospitals were taken over by CCSS between 1974 and 1978, as were hospitals owned by the banana companies at a slightly later stage. Ultimately, all hospitals (including those previously owned by the Ministry of Health) were integrated into the CCSS network of providers. By 1975, 90% of doctors were social security employees (this had risen to 95% in 1981). Nevertheless, a third of all doctors undertake some form of limited private practice.

The CCSS was ultimately responsible for all PHC and hospital based medical care to individuals, although the Ministry of Health (MoH) retained some PHC facilities to provide care to the population not covered by the CCSS during the transition to universal coverage. The MoH was primarily responsible for environmental health, infectious disease vector control and community-based PHC. The latter program consists of auxiliary health workers with six-months training who regularly visit each

household in their area to provide health education and vaccinations, undertake malaria and TB surveillance, monitor the growth and nutritional status of children and to refer patients to CCSS clinics and hospitals.

This innovative community-based PHC program has been hailed as a success story, and has been identified as a major contributory factor to the dramatic decline in the IMR from 68 per 1,000 live births in 1970 to 20 per 1,000 in 1980, the 98% reduction in deaths from infectious and parasitic diseases and eradication of poliomyelitis and diphtheria during this time. While IMR had been declining by an average of 2.3% per year between 1955 and 1972, it decreased six times more rapidly (an average of 12.9% per year) between 1972 and 1980. Health status indicators by 1980 were second only to Cuba within the Latin America and Caribbean region. Although the PHC program and the health system changes associated with the move towards universal mandatory insurance were credited with reducing socioeconomic differentials in children's risk of death and dramatically reducing mortality, other factors also contributed. The overall social security system, including free and compulsory education, and socioeconomic development have also played an important role in achieving these health status improvements.

3. CURRENT STRUCTURE OF THE HEALTH SYSTEM AND HEALTH INSURANCE

Costa Rica has achieved near universal (about 90%) coverage of its population through its national health insurance system. The current contribution rate for formal sector workers is equivalent to 15% of their salary, with the employer contributing 9.25%, the employee contributing 5.5% and government making a 0.25% contribution. In the case of the self-employed, government now pays about 50% of their contributions. The government pays the full CCSS contribution on behalf of the poor, handicapped and elderly from general tax funds. The contributions of about 12% of CCSS members who fall into these groups are fully subsidised by government. The CCSS also receives revenue from the national lottery and certain dedicated taxes. There is no allowance for 'opting out' in the Costa Rican mandatory health insurance – i.e. all are expected to belong to the insurance and to pay

contributions (except for those who are fully subsidised) whether or not they choose to make use of the CCSS services.

Thus, almost all Costa Ricans are covered under a single mandatory insurance system, with revenue being obtained both from payroll contributions and substantial tax revenue contributions. In addition, Costa Ricans use the same facilities, receive the same services and are eligible for the same benefit package. As indicated previously, the CCSS owns the vast majority of health facilities in Costa Rica. It is only in recent years that the private sector has begun to develop. About 10% of the population (the wealthiest) is estimated to use private sector services, mainly general practitioner care and limited ambulatory specialist care. These private sector services are not covered by the mandatory insurance and thus are paid for on an out-of-pocket basis.

Although there are no empirical data available on the relative progressivity of overall health care funding in Costa Rica, the lack of a maximum cap on payroll contributions, inability to 'opt out' of CCSS, and the full tax funding for vulnerable groups through a unitary funding system suggests strong progressivity (wealthy to poor cross-subsidy) in the Costa Rican health system. In addition, risk pooling (healthy to ill cross-subsidy) is maximised as the mandatory insurance effectively pools risk for 90% of the population. The poor benefit disproportionately from public sector expenditure with 28% of the benefit from public health care expenditure accruing to the poorest 20% of households and only 11% to the richest 20%.

There are reasonably good utilisation rates, of over 3 outpatient visits per person per year on average. Importantly, there is very little difference in utilisation rates between different socio-economic groups and between rural and urban areas. This suggests good physical and financial access to health services in Costa Rica. Special efforts have been made to ensure an equitable distribution of health workers, with new graduates being offered posts in rural and PHC facilities from where they can 'work their way up' to more 'prestigious' facilities.

In the late 1990s, the CCSS decided to reorganise its health services and partially separate its financing and service provision functions through introducing performance agreements. In particular, it established integrated basic health care

teams (EBAIS) at the primary care level, consisting of a general practitioner, auxiliary nurse and a primary health care technician. Each EBAIS is expected to provide integrated preventive, promotive and curative services to a population of about 4,000. EBAIS were first introduced in rural and marginalised urban areas and then expanded nationwide. By the end of 2000, there were 670 EBAIS, providing primary care services in close proximity to the vast majority of the population, supported by 83 health area teams. The referral level includes 13 peripheral hospitals, 7 regional hospitals, 6 specialised hospitals (e.g. psychiatric, geriatric, substance abuse facilities) and 3 national hospitals providing a full range of highly specialised services.

The performance management reform included establishing contracts between the CCSS and individual hospitals, whereby each hospital commits to reaching certain targets. A percentage of the annual budget for hospitals (initially 10%) was allocated on the basis of performance in relation to these targets. It is envisaged that ultimately all funding will be allocated on the basis of outputs (along the lines of a diagnosis-related group or DRG payment system) with the historical budgeting process being phased out. The intention of these reforms was to promote efficiency and quality of care. However, the performance based payment system has yet to be fully implemented, partly due to difficulties in securing adequate information for evaluating performance of individual facilities.

What has been more successfully implemented is a needs-based resource allocation mechanism for the primary health care level. Under this arrangement, budgets to health areas (which in turn fund the EBAIS) are allocated on the basis of the size of the population in each area, adjusted for the sex and age composition and level of ill-health (with IMR being used as a proxy measure).

4. KEY ISSUES

Probably one of the most important aspects of Costa Rica's successful efforts to achieve universal health care coverage has been the consistent commitment by government to funding health care. For example, when Costa Rica experienced a period of economic crisis in the 1970s, the government continued its existing level of funding for health services, albeit incurring a growing budget deficit, which it then

reduced when economic growth rates improved. The only period when the government reduced health and other social spending was in the 1980s when they received an IMF loan and a structural adjustment program was imposed. During this period, there was a marked deterioration in health status and an increased reliance on foreign aid to fund the health system. Nevertheless, government increased its health spending as soon as economic recovery began, once again reflecting its commitment to state-sponsored health care.

Another aspect that has been noted by various authors as "the key to the success of Costa Rica's health policy" is the integration of different income groups into a single health system. All Costa Ricans are covered by the same financing mechanism, are entitled to the same benefit package, use the same facilities and receive the same services (although the wealthiest have recently begun to use private general practitioners and specialists for some outpatient care).

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