
The Costa Rican health system: low cost, high value

In 2001 the World Health Organization ranked the small Central American nation of Costa Rica 36th out of 191 countries for health system performance. Experts hail this as the result of health care reforms which changed the structure of the Costa Rican system and dramatically improved primary health care (PHC). Costa Rica, which has a population of 3.8 million, famously abolished its army in 1947, which means that it can, at least in theory, spend on the social sector what other countries spend on arms and armed forces.

The process of reform began nearly 40 years ago when it was decided that the health ministry should assume the role of steward rather than provider — formulating policy coordinating the services, and informing the public. The Costa Rican Social Security Institute (CCSS) was put in charge of financing and providing services to the population.

The CCSS made a push towards universal health care coverage, replacing the previous system which only encompassed the working population. In 1970 47% of the total population was insured, today that figure is 89%. In 1996 the need to improve service and lower costs by strengthening the PHC system was recognized. Health spending had risen to almost 10% of gross domestic product (GDP) but without a corresponding rise in the volume and quality of services. The aim was to bring essential services closer to the population and to increase the capacity of district-level clinics. This was where the real process of reform began.

"The reforms were designed to allow the CCSS to maintain or decrease expenditure while increasing production and patient satisfaction," says Miguel Carmona, President of Costa Rica's Red Cross. "In this they have been successful."

Changes were intended to increase quality and decrease waiting lists, to decentralize the service and raise accountability at the local level.

"The problem before was that the population was not cared for in a holistic sense," says James Cercone, President of SANIGEST, a consulting and management company in Costa Rica's capital San José. "The CCSS treated and paid for patients, but there was very little interest in primary health care such as prevention, diet and education."

One of the most successful elements of reform was the introduction of EBAIS (Basic Health Attention Teams) responsible for a community's physical and social needs. The Costa Rican system was divided into 29 hospital providers and 90 health zones. Each zone was further divided into 10 EBAIS. A minimum EBAIS consisted of a doctor, a nurse and a technician for a population of around 4000.

Management contracts were introduced between the CCSS and health facilities. Purchaser and provider became separated, replacing the old system that had operated under a budget and planning model. The approval of a Law on Decentralization in 1998 consolidated efforts to devolve authority and responsibility to public providers.

This encouraged providers to implement a care model and follow CCSS standards. Through the management contract the CCSS purchasing department established indicators for over 124 provider organizations which included targets for coverage, quality, efficiency and user satisfaction.

A national health plan was approved and investments were restructured, allocating resources where they were most needed. Through parallel efforts to improve efficiency in social security collections, the quantity of these resources also grew, reflecting improved efficiency in the collection of social security contributions from the public.

The autonomy of health providers increased, with greater control

over their finances and the power to implement organizational changes. Incentives for achieving goals were raised because 10% of a hospital's budget was withheld and rewarded later for good performance.

Over the last decade investment from development finance institutions including the World Bank and the Inter American Development Bank has been US\$ 123 million. The Costa Rican Government has contributed roughly US\$ 200 million to finance the recurrent costs and strengthen PHC services.

Cercone says that total benefits are conservatively more than US\$ 409 million and the investment rate of return is nearly 70%.

"This means that for every dollar invested US\$ 1.5 has been returned to the population in terms of improved health status, greater productivity and better quality," he says. In the Central American region, the Costa Rican system is uniquely successful.

According to Cercone this has a lot to do with political stability and a clear national consensus on what the health reforms should do. In addition, where other Central American countries spend less than 3% of GDP on public health, Costa Rica spent 6.4% this year.

However, Dr Zeidy Arce who works as a general practitioner in San José says that there is still not enough money in the health system.

"The Government needs to invest more for the reforms to realize their potential," she says. "There are changes still waiting to be made and waiting lists are long."

Despite a general air of enthusiasm for reform most people agree that there are still problems and that progress is slow in some areas. Mary Clark, a researcher at Tulane University in Louisiana, criticized in particular the way in which the reforms do not in fact succeed in concentrating resources where they are most needed.

"There are budget issues because hospitals are not being held sufficiently accountable yet," she says "Particularly in regional hospitals the directors still do not have enough control over either budgets or staffing."

Dr Marcela Vives who is in charge of Strategic Development at Costa Rica's Health Ministry agrees

that reform has come more gradually than some would like.

"This is an ongoing process of improvement and modernization," she says. "We have a long way to go but already we have a system that most developed countries would be proud of. Certainly, we could teach the United States a thing or two about health care." ■

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