



Universal Health Coverage Assessment

Costa Rica

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Global Network for Health Equity (GNHE)

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Introduction

This document provides a preliminary assessment of the Costa Rican health system relative to the goal of universal health coverage, with a particular focus on the financing system and related aspects of provision.

In the 2010 World Health Report, universal health coverage is defined as providing everyone in a country with financial protection from the costs of using health care and ensuring access to the health services they need (World Health Organisation 2010). These services should be of sufficient quality to be effective.

This document presents data that provide insights into the extent of financial protection and access to needed health services in Costa Rica.

Key health care expenditure indicators

This section examines overall levels of health expenditure in Costa Rica and identifies the main sources of health financing (Table 1).² In 2012 total health expenditure accounted for 10.1% of the country's Gross Domestic Product (GDP), an amount that was substantially higher than the average of 6.1% for other upper-middle-income countries and even higher than the global average of 9.2%.

Public allocations to fund the health sector (including Social Security)³ were around 28% of total government expenditure. This was more than double the average of 12% for other upper-middle-income countries. It was close to double the 15% target set by the Organisation for African Unity's 2001 Abuja Declaration (which,

Table 1: National Health Accounts indicators of health care expenditure and sources of finance in Costa Rica (2012)

Indicators of the level of health care expenditure	
1. Total expenditure on health as % of GDP	10.1%
2. General government expenditure on health as % of GDP	7.6%
3. General government expenditure on health as % of total government expenditure	27.7%
4a. Per capita government expenditure on health at average exchange rate (US\$)	709.6
4b. Per capita government expenditure on health (PPP \$)	978.0
Indicators of the source of funds for health care	
5. General government expenditure on health as % of total expenditure on health*	74.6%
6. Private expenditure on health as % of total expenditure on health	25.4%
7. External resources for health as % of total expenditure on health**	0.0%
8. Out-of-pocket expenditure on health as % of total expenditure on health	23.1%
9. Out-of-pocket expenditure on health as % of GDP	2.3%
10. Private prepaid plans on health as % of total expenditure on health	1.3%

Notes:

* This includes general government taxes and payroll tax-funded mandatory health insurance.

Source: Data drawn from World Health Organisation's Global Health Expenditure Database (http://apps.who.int/nha/database/Key_Indicators/Index/en).

² The data quoted in this section all derive from the 2012 data in the World Health Organisation's Global Health Expenditure Database (<http://apps.who.int/nha/database/Home/Index/en>). Comparisons with other countries are based on figures expressed in terms of purchasing power parity. The country's income category is determined from the World Bank's classification for the same year (<http://data.worldbank.org/about/country-and-lending-groups>).

³ Different countries use the terms 'national health insurance,' 'social health insurance' and 'social security' differently to describe different types of mandatory health insurance. In each country assessment in this series, the term applied is the one commonly in use in the country in question. Costa Rica uses the term Social Security Fund (or Caja Costarricense del Seguro Social (CCSS)). This Fund administers both the largest pension fund and also a mandatory health insurance scheme that covers the bulk of the population.

coincidentally, was the same as the global average for 2012). This demonstrates the Costa Rican government’s strong commitment to funding the health sector.

In fact, government health expenditure translated into 7.6% of GDP in 2012, a figure that was almost double the upper-middle-income country average of 3.4%. This is high for the mandatory pre-paid component of a health financing system. The global average, for example, was 5.3%.

This level of government spending on health care translated into \$978 being spent per person in 2012 (in terms of purchasing power parity). This was more than two-and-a-half times the upper-middle-income country average of \$371, and one-and-a-half times the global average of \$652.

As would have been expected from the high levels of government expenditure, out-of-pocket payments played a relatively small role in Costa Rica (at 23% of total financing in 2012). This was very close to the 20% limit suggested by the 2010 World Health Report to ensure that financial catastrophe and impoverishment as a result of accessing health care become negligible (World Health Organisation 2010).

Finally, in 2012 private health insurance played a very small role at only 1% of total health sector financing. This was much lower than the upper-middle-income-country average of 7% and global average of 15%.

Structure of the health system according to health financing functions

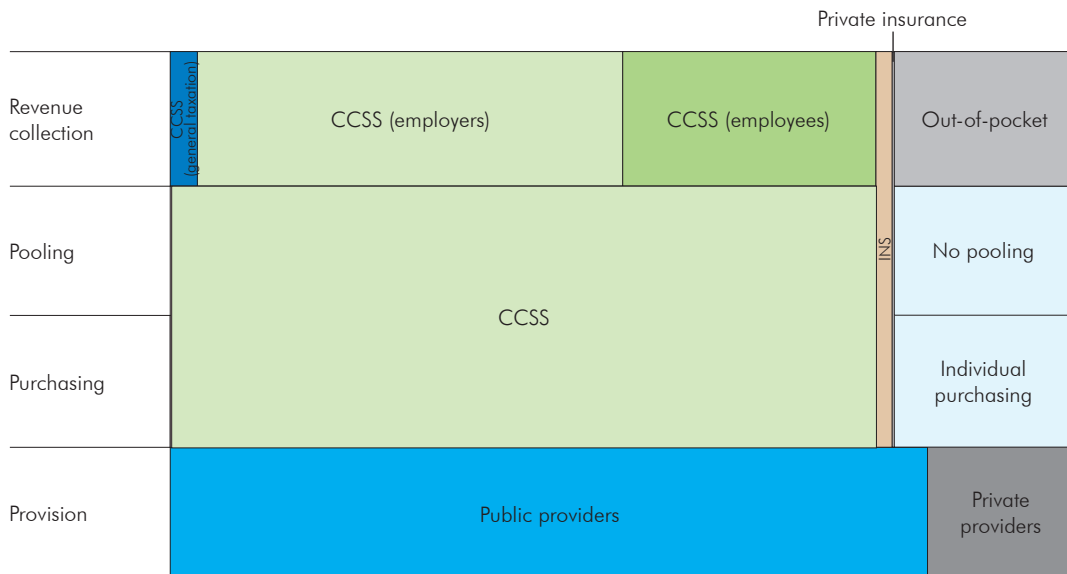
Figure 1 provides a summary of the structure of the Costa Rican health system, depicted according to the health care financing functions of revenue collection, pooling and purchasing, as well as health service provision. Each block represents the percentage share of overall health care expenditure accounted for by each category of revenue source, pooling organisation, purchasing organisation and health care provider.⁴

Revenue collection

In 1961 only 17% of the Costa Rican population was covered by mandatory health insurance, yet, according to the latest national census, coverage had expanded to 86% by 2011. This expansion was the result of a gradual process initiated in 1943. From that time, the original mandatory insurance for public sector employees evolved first to include their dependents, then farm workers and then voluntary contributors. In this way coverage increased. One of the later groups to be included mandatorily were self-employed workers.

These changes were achieved through multiple reforms that built on a health system that had initially been made up mainly of private for-profit and non-profit organisations,

Figure 1: A function summary chart for Costa Rica (2014)



* This information is based on 1998 data for outpatient services only (Herrero and Durán 2001). Further research is required to determine the true split between different types of providers, including hospital and other care.

Source: Calculations by the author based on data from Caja Costarricense del Seguro Social (CCSS), Ministry of Health of Costa Rica and Banco Central de Costa Rica.

⁴The data quoted in this section are slightly different from the previous section because they are based on more detailed disaggregation of different data sources.

with only minor participation by the public sector. In 1941 the Costa Rican Social Security Fund (Caja Costarricense del Seguro Social (CCSS)) was established. This Fund manages two large schemes: one is a public fund for pensions, which is the main pension fund; the other is mandatory health insurance, which is called the Sickness and Maternity Insurance.

In 1973 the General Health Act transferred management of the hospital network from the Ministry of Health to CCSS. The latest major reform was in 1990 with its main focus the strengthening of primary health care. Rosero (2004) and Cubero (2010) agree that the 1990 reform contributed to the reduction of the infant mortality rate from 19.1 per thousand births to 8.5 in 2012.

The CCSS collects its revenues through compulsory deductions from payrolls. These deductions use a tripartite financing system: 9.25% of the payroll is contributed by employers, 5.5% by employees and 0.5% by the government (amounting to 15.25% of the payroll in total).

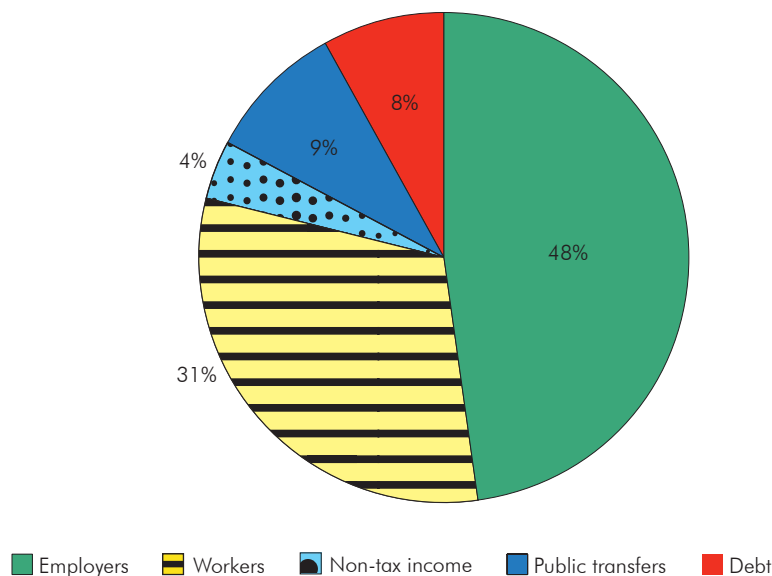
The CCSS collected 78% of all health financing in Costa Rica in 2014 (see Figure 2). In 2014, 48% of revenues for the Sickness and Maternity Insurance came from employers and 31% from employees. This means that 79% of the funds for the insurance scheme are in the form of a direct tax on the income of workers and firms.

Constitutionally, Costa Rica recognises the right to health and access to health care is free at the point of use. If patients are insured there is no co-payment and the total cost of the health care provided is covered by insurance. If patients are not affiliated to the mandatory health insurance system, they must pay for their health care after they receive treatment. If they are unemployed, they have to make an arrangement to pay for the care once they get a job. For the uninsured, services are charged at what the services cost to provide, which is lower than market prices, because CCSS does not seek to make profits. Some informal workers or unemployed people such as students are covered indirectly through their family members' insurance cover.

Costa Rica has another public insurance scheme administered by the National Insurance Institute (INS). This is an institution created to protect against the risk of injuries in the workplace or as a result of motor vehicle or other accidents. There is a third type of health insurance, also offered by the INS, which is a precautionary payment for health expenses not related to accidents. These insurance schemes account for approximately 1.8% of total health financing, and it is a simple private health insurance that the insured can use as a complement to, or a substitute for, the CCSS insurance for any private health services of their choice.

Voluntary commercial health insurance makes up 0.2% of total health financing in Costa Rica, and is purchased by users who want to have additional insurance. For example,

Figure 2: Revenue sources for the Sickness and Maternity Insurance of CCSS (2014)



Source: Author's calculations based on data from the CCSS

Note: Public transfers are transfers made by the central government, and debt is from loans made by CCSS

foreign firms sometimes offer private insurance to their employees so they access services more quickly than they would otherwise do in the public system, or if they wish for a higher standard of care.⁵

The remaining 20%⁶ of health financing is through out-of-pocket payments. These payments are mainly by patients who use services in the private sector because of long waiting lists in the public system, or who want access to pharmaceuticals that are not available in the public system.

Pooling

CCSS represents a large risk pool, collecting contributions from all sub-components of the population and pooling risks across the system, thereby allowing lower-income and higher-risk groups to access health services.

The other insurance schemes make up much smaller risk pools, whereas out-of-pocket payments are not pooled at all.

Purchasing

The package of services that CCSS provides covers all the health needs of the population. Where a patient needs a different type of service or medicine than usually offered, the patient has to provide a justification that is assessed by the CCSS. The Constitutional Court has recently intervened in order to arbitrate some of these cases.

Purchasing of services is carried out mainly by the CCSS. Among the services it purchases are health care cooperative services, which are non-governmental organisations managed by associations of physicians and workers. Also, some external services, such as laboratory tests, are purchased by the CCSS. These cooperatives work on a geographically delimited area. Some of the services provided could be bought from private providers in case CCSS cannot offer the service in that moment for any justified reason, such as malfunction of the equipment.

Within the CCSS there is a process of historic budget allocation, although the reform of 1990 introduced a gradual process of changing this to a 'goals commitment' system. The goals commitment is a system where health centres plan to give certain services to the population they are supposed to cover: if they achieve a different level by the end of the period assessed then the budget is revised for the next period. The aim is to achieve higher efficiency levels and an appropriate allocation of resources relative

to the population covered, which would ensure more equitable provision for the population.

Provision

Twenty-eight percent of the CCSS budget is spent on the primary care level, including preventive and curative services.⁷ These activities are offered mainly by Basic Assistance Teams (or EBAIS), which have a technical assistant, a physician and a nurse, as well as by small-scale health centres. The focus of these teams is on preventive care and low complexity services. They are located in communities and do home visits.

Of the outpatient services provided by the CCSS, 28% are emergencies, 68% are regular outpatient services and 5% are mixed or 'company' services. The latter category are services provided by private physicians, in their own offices, private clinics, private hospitals or in a public facility. The patient pays part of the cost of the service but part is covered by the CCSS (for example, medicines).

Secondary level services account for 35% of the budget and are provided through regional hospitals and clinics. Thirty-seven per cent of the budget is spent at centres dealing with more complex cases, such as national hospitals.

Other public health services are provided by other public institutions, such as services dealing with drug abuse and alcoholism, as well as research and teaching, among others.

Although the entire CCSS-insured population has access to CCSS services, problems with waiting lists for outpatient services and surgery means that some patients prefer to use private services. These include independent physicians and dentists, private clinics and hospitals. Pharmacy services are integrated in the public system but they are also widespread in the private market. Services like odontology are mainly provided by the private sector.

The National Insurance Institute has its own hospital oriented towards trauma services to treat people injured in work-related and motor vehicle accidents.

Financial protection and equity in financing

A key objective of universal health coverage is to provide financial protection for everyone in the country. Insights

⁵ One limitation of this country profile is that information for the private health sector in Costa Rica is scarce.

⁶ It is important to point out that this 20% is calculated as the difference of total expenditure on health that is not public, which is the methodology used by WHO health indicators.

⁷ Author's calculations based on budget execution data from the Finance Department, Budget Division, Caja Costarricense del Seguro Social.

into the existing extent of financial protection are provided through indicators such as the extent of catastrophic payments and the level of impoverishment due to paying for health services. This section analyses these indicators for Costa Rica and then moves on to assess the overall equity of the health financing system. Unfortunately Costa Rica does not have data on how impoverishment was worsened by catastrophic health expenditures.

Catastrophic payment indicators

In Costa Rica in 2012 one per cent (1.26%) of the population incurred catastrophic spending as a result of accessing health care (where financial catastrophe was defined as household out-of-pocket spending on health care in excess of the threshold of 40% of non-food household expenditure) (Campos, Slon and Vargas 2015). It is agreed in the international literature that this indicator is difficult to interpret as it can understate the actual problem. This is because it may not capture the reality that there are people who do not utilise health services when needed because they are unable to afford out-of-pocket payments at all (Wagstaff and van Doorslaer 2003).

Impoverishment indicators

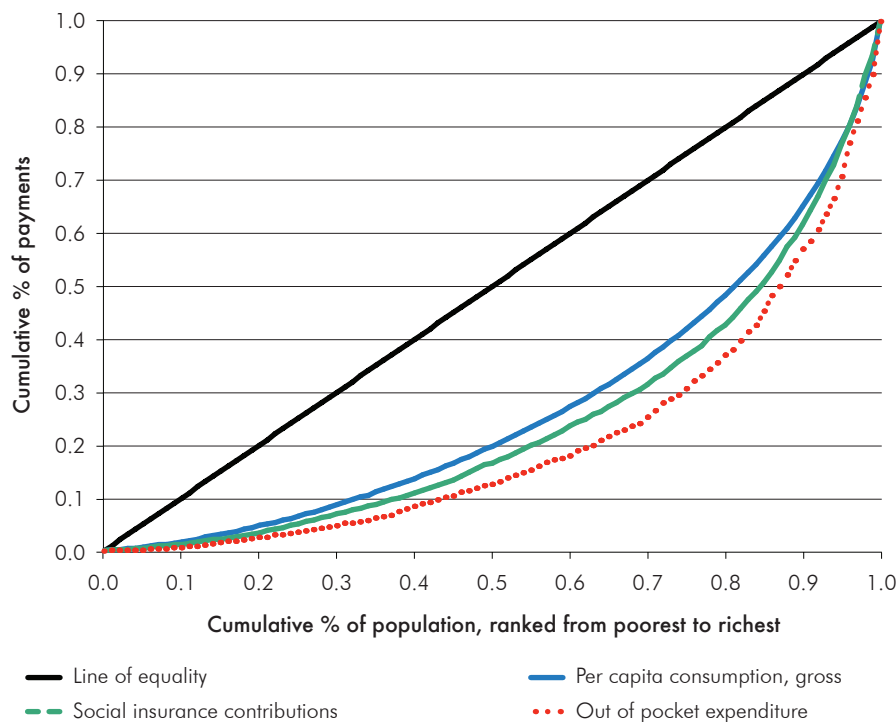
While the extent of catastrophic payments indicates the relative impact of out-of-pocket payments on household welfare, the absolute impact is shown by the impoverishment effect. In Costa Rica, 1.7% of the population lived below \$1.9 per day in 2012.

Equity in financing

Equity in financing is strongly related to financial protection (as described by the indicators above) but is a distinct issue and health system goal. It is generally accepted that financing of health care should be according to the ability to pay.

A 'progressive' health financing mechanism is one in which the amount richer households pay for health care represents a larger proportion of their income. Progressivity is measured by the Kakwani index: a positive value for the index means that the mechanism is progressive; a negative value means that poorer households pay a larger proportion of their income and that the financing mechanism is therefore regressive.

Figure 3: Concentration curves for health payments, insurance and out-of-pocket payments of the public health system



Source: Author's calculations using data from the CCSS

In Costa Rica, the highest quintile of households by income pays more than half (57%) of the contributions to the CCSS, whereas the lowest quintile only pays 3%. The Kakwani index mandatory health insurance contributions and out-of-pocket expenditure is 0.0524 and 0.12 respectively, confirming that the system is mildly progressive. This is because the index is almost zero for health insurance contributions, while out-of-pocket expenditure is carried more by the highest quintile.

The Kakwani index can also be calculated before and after making health payments. This allows the total redistributive impact of the health care financing system to be calculated. In Costa Rica, this index for mandatory health insurance contributions is 0.0018 and for out-of-pockets payments is 0.0046, which means that there is a decrease in inequality due to health financing, because the index is very low.

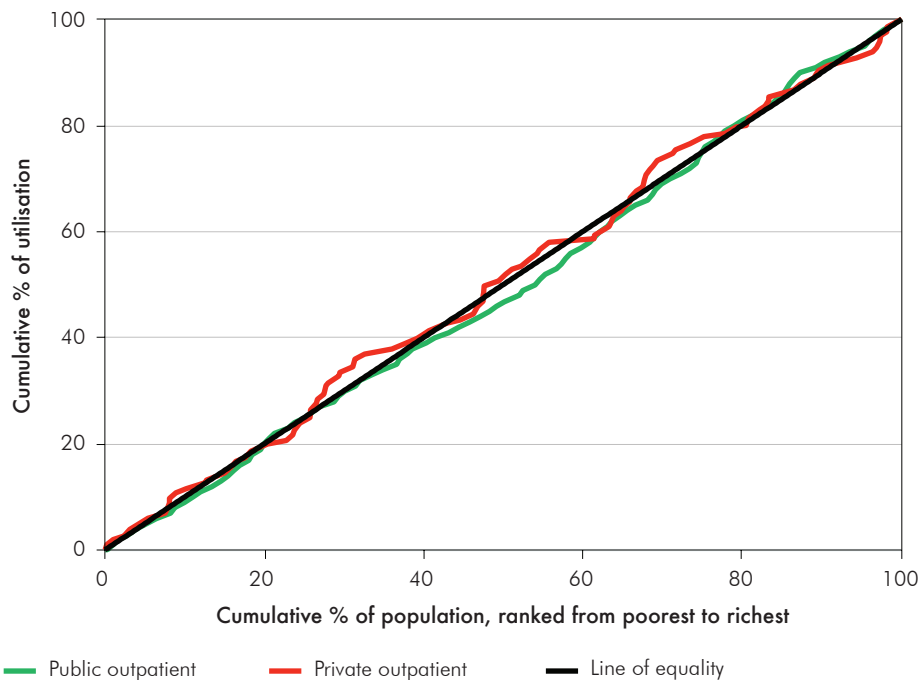
Figure 3 demonstrates this graphically as it presents the concentration curves for gross per capita consumption, mandatory health insurance contributions and out-of-pocket payments. The concentration curves compare cumulative expenditure (on the y axis) with cumulative income (on the x axis), and the black line indicates 'the line of equality,' where everyone contributes the same amount, regardless of income.

Figure 3 shows that per capita consumption is closer to the line of equality compared to the other curves. The prepaid contributions to the CCSS - 60% of which is the health insurance contributions paid by workers, the other 40% being for pensions - is the next line to the right, followed by out-of-pocket expenditure. This means that prepaid contributions and out-of-pocket expenditures affect the richest people more than the poorest. In other words, these expenditures rise as income rises, which means, in other words, that the system is progressive.

Equitable use of health services and access to needed care

This section considers how benefits from using different types of health services are distributed across socio-economic groups. One measure of this is a concentration index, which shows the magnitude of socioeconomic-related inequality in the distribution of a variable. With data from the National Health Survey 2006 it is also possible to see that there is equity in public health care provision (Slon and Vargas 2013) (see Figure 4). This is because, in spite of waiting lists, there is equal access for people from high- and low-income households.

Figure 4: Concentration curves for public outpatient services in Costa Rica (2006)



Source: Slon and Vargas (2013)

What is not known, however, is whether the provision of health care is in line with individuals' need for care. The universal coverage goal of promoting access to needed health care can be interpreted as reducing the gap between the need for care and actual use of services, particularly differences in use relative to need across socio-economic groups. Unfortunately data on this are not available in Costa Rica.

Conclusion

One of the main features of the Costa Rican health system is the existence of a single health insurance fund, just as in the United Kingdom, France and Canada. Prepayment is mandatory for the whole working population and employers, and health insurance coverage in 2011 was 86%. Health services are provided mainly by this health insurance fund, with the coexistence of private sector provision. Health services are free at the point of access.

There is equal access to public health services because there is high coverage in terms of provision. There is also equality of financial risk protection. The factors explaining these achievements include various institutional factors and health system characteristics.

One of the explanatory factors is the fact that Costa Rica 'started small' with an early political agreement to develop a Bismarck-style insurance system for the working class (Slon and Vargas 2013). A gradual process of including progressively more groups into this insurance system played a major role.

The existence of a tripartite financing scheme – involving employers, employees and the state in contributing to a common fund – creates cross-subsidies that allow access to health care across different population groups. Having a single risk pool is also a key factor. The existence of a private sector that complements the public sector allows those who do not want to use public services to reduce

the demand on the public system. Last, but not least, low income-inequality and poverty within the country helps to reduce economic barriers to accessing health services. Democratic institutions and the rule of law support the performance of the health system through accountability, supervision, law enforcement and regulation.

However, the fact that the public health insurance fund is the main revenue collector, purchaser and provider creates some conflict of interests from the perspective of regulation. This is because the lack of separation of functions weakens the allocation process and oversight of performance. It also gives the fund enormous economic and political power, constraining the stewardship role that should be played by the Ministry of Health.

A future challenge is to ensure the financial sustainability of the National Health System in the face of demographic changes, with the proportion of elderly people growing. There is also an epidemiological challenge because chronic diseases are becoming more prevalent. Finally, as already indicated there is a portion (14%) of the population that is not insured. Although they can access care if they require services, they have to pay fees for these services, which can impoverish them as they could incur into catastrophic expenditures. An additional problem is that this segment of the population mainly accesses emergency services, and they are not able to get appointments for outpatient services. Insuring this remaining portion of the population and charging for services properly after they have been used are important challenges.

Finally, more data are needed to understand whether the Costa Rican health care system is closing the gap between health care needs and health care provision, especially across all socio-economic groups. There are some indications that there are remaining differentials in actual and perceived health status across different income quintiles. As it was mentioned before, the waiting lists prevent some patients receiving prompt attention.

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GNHE is a partnership formed by three regional health equity networks – SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries Network in Africa), EQUITAP (Equity in Asia-Pacific Health Systems Network in the Asia-Pacific, and LANET (Latin American Research Network on Financial Protection in the Americas). The three networks encompass more than 100 researchers working in at least 35 research institutions across the globe.

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